Missouri Medicaid

Professional Billing Book

Missouri Department of Social Services

Division of Medical Services

Created by the Provider Education Unit

MISSOURI MEDICAID
PROFESSIONAL BILLING BOOK
INDEX

PREFACE

This Professional Training Booklet contains information to help you submit claims correctly. The information is only recommended for Missouri Medicaid providers and billers if your Medicaid provider number begins with 20, 24, 25, 30, 35, 36, 42, 50, 51, 52, 54, 55, 70, 71 and 91. The booklet is not all-inclusive of program benefits and limitations; providers shoud refer to specific program manuals for entire content.

SECTION 1
MEDICAID PROGRAM RESOURCES
Informational Resources available at www.dss.mo.gov/dms

CONTACTING MEDICAID

PROVIDER COMMUNICATIONS

The following phone numbers are available for Medicaid providers to call the Provider Communications Unit with provider inquiries, concerns or questions regarding proper claim filing, claims resolution and disposition, and recipient eligibility questions and verification. The toll free line provides an interactive voice response system that can answer questions regarding matters including recipient eligibility, last two check amounts, claim status and procedure code status. Providers must use a touchtone phone to access the system.

Provider Communications	800/392-0938
Interactive Voice Response (IVR)	800/392-0938
Standard Line	573/751-2896

The Provider Communications Unit also processes written inquires. Written inquiries should be sent to:

Provider Communications Unit
Division of Medical Services
PO Box 6500
Jefferson City, Missouri 65102

VERIZON INFORMATION TECHNOLOGIES HELP DESK

573/635-3559

Call this number for assistance in establishing the required electronic claims and remittance advice formats, network communication, HIPAA trading partner agreements and assistance with the Verizon Internet billing service.

PROVIDER ENROLLMENT

Providers can contact Provider Enrollment via email as follows for questions regarding enrollment applications: providerenrollment@mail.medicaid.state.mo.us

Changes regarding address, ownership, tax identification number, name (provider or practice), or Medicare number must be submitted in writing to:

Provider Enrollment Unit
Division of Medical Services
PO Box 6500
Jefferson City, Missouri 65102

THIRD PARTY LIABILITY
573/751-2005
Call the Third Party Liability Unit to report injuries sustained by Medicaid recipients, problems obtaining a response from an insurance carrier, or unusual situations concerning third party insurance coverage for a Medicaid recipient.

PROVIDER EDUCATION
573/751-6683
Provider Education Unit staff are available to educate providers and other groups on proper billing methods and procedures for Medicaid claims. Contact the Unit for training information and scheduling.

RECIPIENT SERVICES
800/392-2161 or 573/751-6527
The Recipient Services Unit assists recipients regarding access to providers, eligibility, covered and non-covered services and unpaid medical bills.

MEDICAID EXCEPTIONS AND DRUG PRIOR AUTHORIZATION HOTLINE
800/392-8030
Providers can call this toll free number to initiate an emergency request for an essential medical service or an item of equipment that would not normally be covered under the Medicaid program, or to request a drug prior authorization. The Medicaid exceptions fax line for non-emergency requests only is 573/636-6470.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) INFORMATION

Billing providers who want to exchange electronic information transactions with Missouri Medicaid can access the *HIPAA Companion Guide* online by going to the Division of Medical Services web page at www.dss.mo.gov/dms and clicking on the HIPAA Companion Guide link in the Quick Link box at the top of the page.

To access the *X12N Version 4010A1 Companion Guide*: 1) select Missouri Medicaid Electronic Billing Layout Manuals; 2) select System Manuals; 3) select Electronic Claims Layout Manuals; and, 4) select X12N Version 4010A1 Companion Guide.

For information on the Missouri Medicaid Trading Partner Agreement: 1) select Section 1 - Getting Started; and, 2) select Trading Partner Registration.

All questions concerning the Trading Partner Agreement or provider testing schedules are to be directed to the Verizon Help Desk, 573-635-3559.

INTERACTIVE VOICE RESPONSE (IVR)
800/392-0938

The Provider Communications Unit toll-free number, 800/392-0938 is answered by an Interactive Voice Response (IVR) unit which requires a touchtone phone. The nine digit Medicaid provider number **must** be entered each time any of the IVR options are accessed. Callers are limited to ten inquiries per call on any of the options. Providers whose numbers are inactive may utilize the IVR only for dates of service during their active status.

Option 1 — Recipient Eligibility

Recipient eligibility **must** be verified **each** time a recipient presents and should be verified **prior** to the service. Eligibility information can be obtained by a recipient's Medicaid number (DCN), social security number and date of birth, or if a newborn, using the mother's Medicaid number and the baby's date of birth. Callers cannot inquire on dates that exceed one year prior to the current date. Callers will be given a confirmation number and this number should be kept as proof of the information received.

Option 2 — Last Two Check Amounts

Using this option, the caller will be given the last two Remittance Advice (RA) dates, RA numbers, and check amounts.

Option 3 — Claim Status

After entering the recipient's Medicaid number (DCN) and the date of service, the caller will be provided the status of the most current claim in the system containing the date of service entered. The caller will be told whether the claim is paid, denied, approved to pay or is being processed. In addition, the system will give the amount paid, the RA date and the Internal Control Number (ICN).

Option 4 — Not currently in use.

Option 5 — Medicaid Information Messages

The caller will be given the option to select from several recorded messages providing the latest information regarding the Medicaid program.

Option 6 — Prior Authorization

This option allows pharmacy providers to verify the status of a prior authorization for an NDC (National Drug Code).

INTERNET SERVICES FOR MEDICAID PROVIDERS

The Division of Medical Services (DMS), in cooperation with Verizon Information Technologies, has an Internet service for Missouri Medicaid providers. Missouri Medicaid providers have the ability to:

- Submit claims and receive claim confirmation files;
- Verify recipient eligibility;
- Obtain remittance advices (RAs);
- Submit Adjustments;
- Submit attachments; and
- View and download public files.

The web site address for this service is www.emomed.com. Without proper authorization, providers are unable to access the site. Only providers who are approved to be electronic billers can enroll and utilize the web site services. To participate in the service, the provider must apply on-line at http://www.medicaid.state.mo.us/Application.html. Each user is required to complete this on-line application in order to obtain a user ID and password. The application process only takes a few minutes and provides the applicant with a real-time confirmation response, user ID and password. Once the user ID and password have been received, the user can begin using the www.emomed.com website. The password can be changed to one of the user's own choice.

Questions regarding the completion of the on-line Internet application should be directed to the Verizon Information Technologies Help Desk, (573) 635-3559.

An authorization is required for each individual person within a provider's office or a billing service who will be accessing the Internet site.

This website, www.emomed.com, allows for the submission of the following HIPAA compliant transactions:

837 Institutional Claims	Batched or Individual
837 Professional Claims	Batched or Individual
837 Dental Claims	Batched or Individual
270 Eligibility Inquiry	Batched or Individual
276 Claim Status Inquiry	Batched or Individual

The following standard responses are generated:

835 Remittance Advice	Batch or Printable RA
271 Eligibility Response	Batch or Individual
277 Claim Status Response	Batch or Individual

Users also have access to provider check amounts and the Claims Processing Schedule for the current fiscal year.

There is no cost for this service except for the cost of an Internet service provider access to the Internet. Additionally, there are no special software requirements. However, the user (provider) must have the proper web browser. The provider must have one of the following web browsers: Internet Explorer 5.0 or higher or Netscape 4.7 or higher. It is strongly recommended that users update and utilize the most recent versions of either of these browser programs. The Internet site is available 24 hours a day, 7 days a week with the exception of being down for scheduled maintenance.

VERIFYING RECIPIENT ELIGIBILITY THROUGH THE INTERNET

Providers can access Missouri Medicaid recipient eligibility files via the web site. Functions include eligibility verification by recipient ID, casehead ID and child's date of birth, or Social Security number and date of birth. Eligibility verification can be performed on an individual basis or in a batch file. Individual eligibility verification occurs in real-time basis similar to the Interactive Voice Response System, which means a response is returned immediately. Batch eligibility verifications are returned to the user within 24 hours.

A batch eligibility confirmation file can either be downloaded for viewing purposes or to be printed.

MEDICAID CLAIMS SUBMISSION THROUGH THE INTERNET

The following claim types, as defined by HIPAA Transaction and Code Set regulations, can be used for Internet claim submissions:

- 837 - Health Care Claim
  - Professional
  - Dental
  - Institutional (hospital inpatient and outpatient, nursing home, and home health care)
- Pharmacy (NCPDP)

The field requirements and filing instructions are similar to those for paper claim submissions. For the provider's convenience, some of the claim input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission.

A batch claim confirmation file can either be downloaded for viewing purposes or to be printed.

NOTE: Currently, some claims cannot be submitted electronically if an attachment is required unless the attachment is one of the following that can be submitted via the Verizon Internet service: Sterilization Consent, Second Surgical Opinion,

Acknowledgment of the Receipt of Hysterectomy Information or SURS 118 Referral forms.

OBTAINING A REMITTANCE ADVICE THROUGH THE INTERNET

The Medicaid program is phasing out the mailing of paper Remittance Advices (RAs). Providers no longer will receive both paper and electronic RAs. If the provider or the provider's billing service currently receive an electronic RA, (either via the emomed.com Internet website or other method), paper copies of the RA are discontinued as of July 20, 2004. Providers and billers are encouraged to move to the Internet to receive RAs.

Receiving the Remittance Advice via the Internet is very beneficial to a provider's or biller's operation. With the new Internet RA, a user can:

- Retrieve the RA the Monday following the weekend claim processing cycle (two weeks sooner than receipt of the paper RA);
- Have access to RAs for 62 days (the equivalent of the last four cycles);
- View and print the RA from the desktop; and,
- Download the RA into the provider's or biller's operating system for retrieval at a later date.

The new Internet RA will be viewable and printable in a ready to use format. Just point and click to print the RA or save it to the computer system for printing at the user's convenience.

If the provider or the biller receives a paper copy of the RA only and not an electronic copy, please consider moving to the Internet to receive the RAs. To sign up for this new, see the instructions at the beginning of this information.

Please note – once signed up to receive the RAs via the Internet, receipt of paper RAs by the provider or a billing service will be discontinued.

ADJUSTMENTS THROUGH THE INTERNET

Providers have options on the Internet Medical, Dental, Inpatient, Outpatient and Nursing Home claims for a "Frequency Code" that will allow either a 7 – Replacement (Adjustment) or an 8 – Void (Credit). This will control an individual adjustment or void, but not group adjustments or voids. Claim adjustments and credits can be submitted by utilizing the CLM, field CLMO5-3, segment of the 837 Health Care Claim.

RECEIVE PUBLIC FILES THROUGH THE INTERNET

Several public files are available for viewing or downloading from the web site including the claims processing schedule for the State fiscal year which begins July 1 and ends June 30. Providers also have access to a listing of the Adjustment Reason Codes and Remittance Advice Remark Codes.

SUBMIT ATTACHMENTS AND FORMS THROUGH THE INTERNET

Providers can submit required attachments and forms via the Internet as an option to mailing paper versions to Medicaid. A paper copy of any attachment or form submitted via the Internet must be kept with the patient's record. The following forms can be submitted through the Verizon Internet Service.

Sterilization Consent
Second Surgical Opinion
SURS 118 Referral (administrative lock-in)
Acknowledgment of Receipt of Hysterectomy Information

MISSOURI MEDICAID PROVIDER MANUALS ON-LINE
www.dss.mo.gov/dms

How To Download/Print a Provider Manual

The following information assumes you are using a Microsoft Windows based operating system as your operating system. In order to be able to download and use all or a portion of an on-line Medicaid provider manual, you must have Adobe Acrobat Reader. If you already have this on your computer, you may disregard the first section and go directly to the sections detailing how to download and print the manuals.

NOTE: The provider manual information you download is current as of the time it is downloaded. Since periodic updates are made to the manuals, you must do a new download periodically so that your file will have the new or updated information.

A. Accessing and downloading Adobe Acrobat Reader program .

1. Open the DMS home page at www.dss.mo.gov/dms.
2. Scroll down, click on and open the line/link titled "Missouri Medicaid Provider Manuals".
3. In the newly opened page, scroll down and click on the yellow and red box at the bottom of the page titled "Get Acrobat Reader".
4. Once you have opened the Adobe Acrobat page, follow the instructions to download the free Adobe Acrobat Reader program to your computer system. Generally, the program will be installed in the C:/programs folder although you can put it in any folder you want. Download time is approximately 20-30 minutes depending on the speed of your modem and Internet service provider.

B. Downloading and saving all or portions of a provider manual.

1. Go to the DMS home page at www.dss.mo.gov/dms**.**
2. Scroll down, click on and open the line/link titled "Missouri Medicaid Provider Manuals".
3. A new page will open. Click on the link titled "Missouri Medicaid Provider Manuals".

4. On the left side of the newly opened page, click on the “+” in front of the folder titled “Print A Manual” and click again on the subfolder. This opens a new frame in the upper right area of the screen titled “Print a Manual”. In this frame scroll down to the provider manual you want to access and click on the manual to open to its contents page. Disregard the frame in the lower area of the page titled “Search Results”.
5. When the page opens, it will display a number of links from which you can choose the one you want. The links allow you to access either the complete manual or sections of the selected manual.

For Internet Explorer Browser Users

For example, if you wish to download the entire physician's manual, place your pointer on the line/link titled "Complete Manual" and right click. A pop-up menu will appear. Click on the "Save Target As" button. Another pop window (Save As) will appear. Select where you want to save the file and its name. It can be saved either to a floppy disk or to a folder on the hard drive. If you rename the file, be sure to put the .pdf extension at the end of the new name. Click on the save button. The material then will be saved to the location/name you specified. Actual download time will vary depending on the file size of the information you want to download and the speed of your system's modem and your Internet service provider's system. Downloading a complete manual can take 5-10 minutes.

For Netscape Browser Users

For example, if you wish to download the entire physician's manual, place your pointer on the line/link titled "Complete Manual" and right click. A pop-up screen will appear. Click on "Save Link As". In the next pop-up window, select the drive/ folder where you want to save the date. You may rename file if you wish a name other than the name presented by the system. Add or change the file extension to .pdf (at the end of the file name), e.g. change phyman to phyman.pdf. Click save and the data will be saved to the location/name you specified. Actual download time will vary depending on the file size of the information you want to download and the speed of your system's modem and your Internet service provider's system. Downloading a complete manual can take 5-10 minutes.

6. Close the screens all the way back to the browser. Close the browser screen and return to your desktop.

C. Using Adobe Acrobat Reader to access the saved manual file.

1. Open Acrobat Reader either using the desktop icon or the program file.
2. Once the work screen is open, click on "File" in the taskbar.
3. On the task screen, select and click on "Open".
4. Select and highlight the drive location and name of your file. Acrobat Reader then will open your file.

5. You now have the option of viewing or printing all or portions of the file.

D. Printing all or portions of an opened Acrobat Reader Document

1. Click on "File" on the taskbar.
2. On the task screen, select and click on "Print" or "Print Target".
3. You have three options for printing from the file. All - prints the entire file Current Page - prints only the page you have selected/highlighted. Pages - gives you the option to print a specified range of consecutive pages.
4. When the print command has been sent to the printer, select "File" on the taskbar and "Exit" in the task screen to exit the program and return to your desktop.

CLAIM AND ATTACHMENT MAILING ADDRESSES

Medicaid paper claims and attachments related to claims must be sent to the following address as indicated.

Verizon Information Technologies, Inc.
P.O. Box (see below for correct PO box number)
Jefferson City, MO 65102

P.O. Box 5100……. Inpatient Hospital Claims
P.O. Box 5200……. Outpatient Hospital Claims and RHC Claims
P.O. Box 5300……. Dental Claims
P.O. Box 5400……. Pharmacy Form Paper Claims
P.O. Box 5500……. Nursing Home Paper Claims
P.O. Box 5600……. DME, HCFA-1500, and Home Health Agency Claims
P.O. Box 5700……. Prior Authorization Requests
P.O. Box 5900……. Attachments forms including Second Surgical Opinion, Acknowledgment of Receipt of Hysterectomy Information, SURS Referral, Oxygen & Respiratory Equipment Medical Justification and Certificate of Medical Necessity (DME providers only)

Verizon's physical address is: Verizon Information Technologies
905 Weathered Rock Road
Jefferson City, MO 65101

CLAIMS PROCESSING SCHEDULE FOR STATE FISCAL YEAR 2005

Cycle Run/Remittance Date* -	Check Date -
Friday, June 18, 2004	Tuesday, July 6, 2004
Friday, July 9, 2004	Tuesday, July 20, 2004
Friday, July 23, 2004	Thursday, August 5, 2004
Friday, August 6, 2004	Friday, August 20, 2004
Friday, August 20, 2004	Tuesday, September 7, 2004
Friday, September 10, 2004	Monday, September 20, 2004
Friday, September 24, 2004	Tuesday, October 5, 2004
Friday, October 8, 2004	Wednesday, October 20, 2004
Friday, October 22, 2004	Friday, November 5, 2004
Friday, November 5, 2004	Monday, November 22, 2004
Friday, November 19, 2004	Monday, December 6, 2004
Friday, December 3, 2004	Monday, December 20, 2004
Friday, December 17, 2004	Wednesday, January 5, 2005
Friday, January 7, 2005	Thursday, January 20, 2005
Friday, January 21, 2005	Monday, February 7, 2005
Friday, February 4, 2005	Monday, February 21, 2005
Friday, February 18, 2005	Monday, March 7, 2005
Friday, March 11, 2005	Monday, March 21, 2005
Friday, March 25, 2005	Tuesday, April 5, 2005
Friday, April 8, 2005	Wednesday, April 20, 2005
Friday, April 22, 2005	Thursday, May 5, 2005
Friday, May 6, 2005	Friday, May 20, 2005
Friday, May 20, 2005	Monday, June 6, 2005
Friday, June 3, 2005	Monday, June 20, 2005

*The Cycle Run Dates are tentative dates calculated by the Division of Medical Services. The dates are subject to change without prior notification.

*All claims submitted electronically to Verizion, must be received by 5:00 p.m. of the Cycle Run/Remittance Advice date in order to pay on the corresponding check date.

Holidays For State Fiscal Year 2005

July 5, 2004 Independence Day
September 6, 2004 Labor Day
October 11, 2004 Columbus Day
November 11, 2004 Veteran's Day
November 25, 2004 Thanksgiving
December 24, 2004 Christmas
December 31, 2004 New Years Day
January 17, 2005 Martin Luther King Day
February 11, 2005 Lincoln's Birthday
February 16, 2005 Washington's Birthday
May 9, 2005 Truman's Birthday
May 30, 2005 Memorial Day

SECTION 2.
CMS-1500 CLAIM FILING INSTRUCTIONS

The CMS-1500 claim form should be legibly printed by hand or electronically. It may be duplicated if the copy is legible. Medicaid paper claims should be mailed to:

Verizon Information Technologies
P.O. Box 5600
Jefferson City, MO 65102

Information about ordering claim forms and provider labels is in Section 3 of the Medicaid *Providers Manual* available at **www.dss.mo.gov/dms**.

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicates a field is required in specific situations.

Field number and name		Instructions for completion
1.*	Type of Health Insurance Coverage	Show the type of health insurance coverage applicable to this claim by checking the appropriate box. For example, if a Medicare claim is being filed, check the Medicare box, if a Medicaid claim is being filed, check the Medicaid box and if the patient has both Medicare and Medicaid, check both boxes.
1a.*	Insured's I.D.	Enter the patient's eight-digit Medicaid or MC+ ID number (DCN) as shown on the patient's ID card.
2.*	Patient's Name	Enter last name, first name, middle initial *in this order* as it appears on the ID card.
3.	Patient's Birth Date Sex	Enter month, day, and year of birth. Mark appropriate box.
4.**	Insured's Name	If there is individual or group insurance besides Medicaid, enter the name of the primary policyholder. If this field is completed, also complete fields 6, 7, 11, and 13. If no private insurance is involved, leave blank.
5.	Patient's Address	Enter address and telephone number if available.

6.**	Patient's Relationship to Insured	Mark appropriate box if there is other insurance. If no private insurance is involved, leave blank.
7.**	Insured's Address	Enter the primary policyholder's address; enter policy-holder's telephone number, if available. If no private insurance is involved, leave blank.
8.	Patient Status	Not required.
9.**	Other Insured's Name	If there is other insurance coverage in addition to the primary policy, enter the secondary policyholder's name. If no private insurance is involved, leave blank. (See Note)(1)
9a.**	Other Insured's Policy or Group Number	Enter the secondary policyholder's Insurance policy number or group number, if the insurance is through a group such as an employer, union, etc. If no private insurance is involved, leave blank. (See Note)(1)
9b.**	Other Insured's Date of Birth	Enter the secondary policyholder's date of birth and mark the appropriate box reflecting the sex of the secondary policyholder. If no private insurance is involved, leave blank. (See Note)(1)
9c.**	Employer's Name	Enter the secondary policyholder's employer name. If no private insurance is involved, leave blank. (See Note)(1)
9d.**	Insurance Plan	Enter the secondary policyholder's insurance plan name. If no private insurance is involved, leave blank. *If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.* (See Note)(1)
10a.-10c.**	Is Condition Related to:	If services on the claim are related to patient's employment, an auto accident or other accident, mark the appropriate box. *If the services are not related to an accident, leave blank.* (See Note)(1)

10d.	Reserved for Local Use	May be used for comments/descriptions.
11.**	Insured's Policy or Group Number	Enter the primary policyholder's insurance policy number or group number, if the insurance is through a group, such as an employer, union, etc. If no private insurance is involved, leave blank. (See Note)(1)
11a.**	Insured's Date of Birth	Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policyholder. If no private insurance is involved, leave blank. (See Note)(1)
11b.**	Employer's Name	Enter the primary policyholder's employer name. If no private insurance is involved, leave blank. (See Note)(1)
11c.**	Insurance Plan Name	Enter the primary policyholder's insurance plan name. *If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.* (See Note)(1)
11d.**	Other Health Plan	Indicate whether the patient has a secondary health insurance plan. If so, complete fields 9-9d with the secondary insurance information. (See Note)(1)
12.	Patient's Signature	Leave blank.
13.	Insured's Signature	This field should be completed only when the patient has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the provider of Medicaid. Payment may otherwise be issued to the policyholder requiring the provider to collect insurance benefits from the policyholder.
14.**	Date of Current Illness, Injury or Pregnancy	This field is required when billing global prenatal and delivery services. The date

		should reflect the last menstrual period (LMP).
15.	Date Same/Similar Illness	Leave blank.
16.	Dates Patient Unable to Work	Leave blank.
17.**	Name of Referring Physician or Other Source	Enter the name of the referring physician. If the physician is nonparticipating in the Missouri Medicaid Program, enter "nonparticipating." *This field is required for independent laboratories and independent radiology groups (provider types 70 and 71), and providers with a specialty of "30" (radiology/radiation therapy).*
17a.**	I.D. Number of Referring Physician	Enter the referring physician's Medicaid provider number. If the physician is nonparticipating in the Missouri Medicaid Program, enter "nonparticipating." *This field is required for independent laboratories and independent radiology groups (provider types 70 and 71), and providers with a specialty of "30" (radiology/radiation therapy).*
18.**	Hospitalization Dates	If the services on the claim were provided in an in-patient hospital setting, enter the admit and discharge dates. If the patient is still in the hospital at the time of filing, write "still" in the discharge date field or show the last date of in-patient service that is being billed in field 24a. This field is required when the service is performed on an in-patient basis.
19.	Reserved for Local Use	Providers may use this field for additional remarks/descriptions.
20.**	Lab Work Performed Outside Office	If billing for laboratory charges, mark the appropriate box. The referring physician may **not** bill for lab work that was referred out.
21.**	Diagnosis	Enter the complete ICD-9-CM diagnosis code(s). Enter the primary diagnosis as No. 1, the secondary diagnosis as No. 2, etc.

22.**	Medicaid Resubmission	For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely.
23.	Prior Authorization Number	Leave blank**.**
24a.*	Date of Service	Enter the date of service under “from” in month/day/year format, using a six-digit format. All line items **must** have a from date. A “to” date of service is required when billing on a single line for subsequent physician hospital visits on consecutive days.
24b.	Place of Service	Enter the appropriate place of service code. See Section 15.10 of the Medicaid *Physician’s Provider Manual* for the list of appropriate place of service codes.
24c.	Type of Service	Leave blank.
24d.*	Procedure Code	Enter the appropriate CPT or HCPCS code and applicable modifier(s), if any, corresponding to the service rendered. (field 19 may be used for remarks or descriptions.) See Section 7 of this booklet for a list of modifiers used by the Missouri Medicaid program.
24e.*	Diagnosis Code	Enter 1, 2, 3, 4 or the actual diagnosis code(s) from field 21.
24f.*	Charges	Enter the provider’s usual and customary charge for each line item. This should be the total charge if multiple days or units are shown.
24g.*	Days or Units	Enter the number of days or units of service provided for each detail line. The system automatically plugs a “1” if the field is left blank. Anesthesia—Enter the total number of minutes of anesthesia.

		Consecutive visits—Subsequent hospital visits may be billed on one line if they occur on consecutive days. The days/units must reflect the total number of days shown in field 24a. Injections—Only for those providers not billing on the Pharmacy Claim form. Enter multiple increments of the listed quantity administered. For example, if the listed quantity on the injection list is 2 cc and 4 cc are given, the quantity listed in this field is "2."
24h.**	EPSDT/Family Planning	If the service is an EPSDT/HCY screening service or referral, enter "E." If the service is family planning related, enter "FP." If the service is both an EPSDT/HCY and Family Planning service enter "B."
24i.	Emergency	Leave blank.
24j.	COB	Leave blank.
24k.**	Performing Provider Number	This field is required only for a clinic (group practice), FQHC, public health agency, teaching institution or independent radiology group. Enter the Missouri Medicaid provider number of the physician or other professional who performed the service.
25.	SS#/Fed. Tax ID	Leave blank.
26.	Patient Account Number	For the provider's own information, a maximum of 12 alpha and/or numeric characters may be entered here.
27.	Assignment	Not required on Medicaid claims.
28.*	Total Charge	Enter the sum of the line item charges.
29.**	Amount Paid	Enter the total amount received by all other insurance resources. **Previous Medicaid payments, Medicare payments, cost sharing and co-pay amounts are not to be entered in this field.**
30.	Balance Due	Enter the difference between the total

		charge (field 28) and the insurance amount paid (field 29).
31.	Provider Signature	Not Required.
32.**	Name and Address of Facility	If the services were rendered in a facility other than the home or office, enter the name and location of the facility. This field is required when the place of service is other than home or office.
33.*	Provider Name/ Number /Address	Affix the provider label or write or type the information **exactly** as it appears on the label.

* These fields are mandatory on all CMS-1500 claim form.

** These fields are mandatory only in specific situations, as described.

(1) NOTE: This field is for private insurance information only. If no private insurance is involved **leave blank**. If Medicare, Medicaid, employers name or other information appears in this field, the claim will deny. See Section 5 of the Medicaid *Provider's Manual* for further TPL (Third Party Liability) information.

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1.

2.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

SAMPLE

SECTION 3.
THE REMITTANCE ADVICE (RA)

The Remittance Advice shows claim payment or denial. If the claim has been denied or some other action taken affecting the payment, the RA lists an "Adjustment Reason Code" to explain the denial or other action. The Adjustment Reason Code is from a national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payor's reimbursement for it. The RA may also list a "Remittance Remark Code" which is from a national administrative code set for providing either a claim-level or service-level message that cannot be expressed with a claim Adjustment Reason Code.

If a claim is denied, a new or corrected claim form **must** be submitted as corrections **cannot** be made by submitting changes on the RA pages.

Remittance advices for professional services are grouped in the following order.

Crossover Part-B - reimbursement greater than zero
Medical - reimbursement greater than zero
Crossover Part-B - reimbursement equals zero
Medical - reimbursement equals zero
Drug
Adjustments
Credits

Claims in each category are listed alphabetically by the patient's last name.

FIELD NUMBER & NAME		EXPLANATION OF FIELD
1.	Provider Number	The provider's 9-digit Missouri Medicaid number.
2.	Remittance Advice Date	The financial cycle date.
3.	Remittance Advice Number	The Remittance Advice number.
4.	Page	The Remittance Advice page number.
5.	Medical (Claim Type)	The type of claims(s) processed.
6.	Recipient Name	The patient's last name and first name. NOTE: If the patient's name and identification number are *not* on file, only the first two letters of the last name and first letter of the first name appear.

FIELD NUMBER & NAME		EXPLANATION OF FIELD
7.	Medicaid I.D.	The patient's 8-digit Medicaid identification number.
8.	Internal Control Number (ICN)	The 13-digit number assigned to the claim for identification purposes. The first two digits of an ICN indicate the type of claim: 11--Paper Drug 15--Paper Medical 18--Paper Medicare/Medicaid Part B Crossover Claim 40--Magnetic Tape Billing (MTB) includes claims sent by Medicare intermediaries. 41--Direct Electronic Medicaid Information (DEMI) 43--MTB/DEMI 44--Direct Electronic File Transfer (DEFT) 45--Accelerated Submission and Processing (ASAP) 46--Adjudicated Point of Service (POS) 47--Captured Point of Service (POS) 49--Internet 50--Individual Adjustment Request 55--Mass Adjustment 70--Individual Credit to an Adjustment 75--Credit Mass Adjustment The third and fourth digits indicate the year the claim was received. The fifth, sixth, and seventh digits indicate the Julian date. In a Julian system, the days of a year are numbered consecutively from "001" (January 1) to "365" (December 31) ("366" in a leap year). The last digits of an ICN are for internal processing. The ICN number 1503277316020 is read as a paper medical claim entered in the processing system on October 4, 2003. For a drug claim, the last digit of the ICN indicates the line number from the Pharmacy Claim form.
9.	Service Dates	The initial date of service in MMDDYY format followed by the final date of service in MMDDYY format.

FIELD NUMBER & NAME		EXPLANATION OF FIELD
10.	Place of Service (POS)	The 2-digit place of service.
11.	Proc. Code - Mod	The CPT or HCPCS procedure code, including any modifier(s) billed by the provider.
12.	Qty.	The units of service billed.
13.	Billed Amount (Charges)	The amount billed by the provider for the procedure.
14.	Allowed Amount (Charges)	The Medicaid maximum allowed amount for the procedure.
15.	Cut/Back	The difference between the billed amount and the allowed amount.
16.	Payment Amount	The amount Medicaid paid on the claim.
17.	Adjustment Reason Codes	Identifies the reasons for any differences, or adjustments, between the original provider billed amount for a claim or service and Medicaid's payment for it.
18.	Patient Acct	The provider's own patient account name or number.
19.	Remark Codes	Provides either claim level or service level messages that cannot be expressed with an Adjustment Reason Code.
20.	Corrected Priority Pay Name	The state is showing that there is other insurance available for the patient. When a claim denies for other insurance, the name of the commercial carrier is shown. Up to two policies can be shown.
21.	Other Claims Related to ID	The patient's group policy insurance number.
22.	Other Claims Related to ID	The patient's individual insurance policy number.
23.	Category Totals	Each category (i.e., paid crossover, paid medical, denied crossover, denied medical, drug, adjustments) has separate totals for number of claims, billed

FIELD NUMBER & NAME		EXPLANATION OF FIELD
		amount and allowed amount. This field also includes totals for quantity, cutback and other payments, if applicable.
24.	Provider Totals	Totals for this provider for this RA.
25.	Spenddown Amount	Total spenddown amount(s) for this provider for this RA.
26.	Earnings Data	Shows fiscal year-to-date total of claims processed and reimbursements paid to the provider.

PROVIDER NUMBER: 200000000 (1) STATE OF MISSOURI MEDICAID RA # 09999999 (3)
MEDICAL (5) REMITTANCE ADVICE AS OF 10-10-03 (2) PAGE 2 (4)

RECIPIENT NAME (6)	MEDICAID I.D. (7)	INTERNAL CONTROL NUMBER (8)	SERVICE DATES FROM MMDDYY (9)	TO MMDDYY	P O S (10)	PROC CODE-MOD (11)	QTY (12)	BILLED AMOUNT (13)	ALLOWED AMOUNT (14)	CUT/ BACK (15)	PAYMENT AMOUNT (16)	ADJUST REASON CODES (17)
KROSS,IMA	09004999	1503279009999	092903	092903	11	99213	1	42.44	24.00	18.44-	24.00	A2
		PAT ACCT: KR025										
(18)			092903	092903	11	85024	1	35.00	11.70	23.30-	11.70	A2
			092903	092903	11	82948	1	18.00	1.00	17.00-	1.00	A2
			092903	092903	11	83036	1	40.00	13.41	26.59-	13.41	A2
			092903	092903	11	80061	1	50.00	18.51	31.49-	18.51	A2
			****CLAIM TOTALS :				5		68.62		68.62	
								185.44		116.82-		
*** REMARK CODES: N59 (19)												
JONES,MARY	05513849	4403280009898	100103	100103	11	99213	1	45.00	24.00	21.00-	24.00	A2
		PAT ACCT: JO398										
(18)			100103	100103	11	82948	1	18.00	1.00	17.00-	1.00	A2
			100103	100103	11	36415	1	4.00	.00	4.00-	.00	125
			****CLAIM TOTALS :				3		25.00		25.00	
								67.00		42.00-		
*** REMARK CODES: N59 MA66 (19)												
SMITH,JOHN	29030841	1503279006789	100103	100103	11	99213	1	42.44	24.00	18.44-	24.00	A2
		PAT ACCT: SM145										
			100103	100103	11	81003	1	12.00	.00	12.00-	.00	125
			****CLAIM TOTALS :				2		24.00		24.00	
								54.44		30.44-		
*** REMARK CODES: MA66 (19)												
SMITH, WILL	77889911	1503279000987	100103	100103	11	99213	1	42.00	.00	42.00-	.00	22
***REMARK CODES: MA92 (19)												

CORRECTED PRIORITY PAYER NAME: (20) DMS HEALTHCARE
OTHER CLAIMS RELATED ID: (21) AA345678
OTHER CLAIMS RELATED ID: (22) 555495755

****CATEGORY TOTALS : (23)	NUMBER OF CLAIMS =	4		11		117.62		117.62	
					348.88		231.26-		
****PROVIDER TOTALS : (24)	NUMBER OF CLAIMS =	4		11		117.62		117.62	
					348.88		231.26-		

SPENDDOWN AMOUNT: .00 (25)

** EARNINGS DATA *** (26)	CURRENT
NO. OF CLAIMS PROCESSED	75
DOLLAR AMOUNT PROCESSED	1,752.71
CHECK AMOUNT	1,752.71

SECTION 4.
INJECTION (PHARMACY) CLAIM FILING INSTRUCTIONS

The Pharmacy Claim form should be typed or legibly printed. It may be duplicated if the copy is legible. Medicaid claims should be mailed to:

Verizon Information Technologies
P.O. Box 5400
Jefferson City, MO 65102

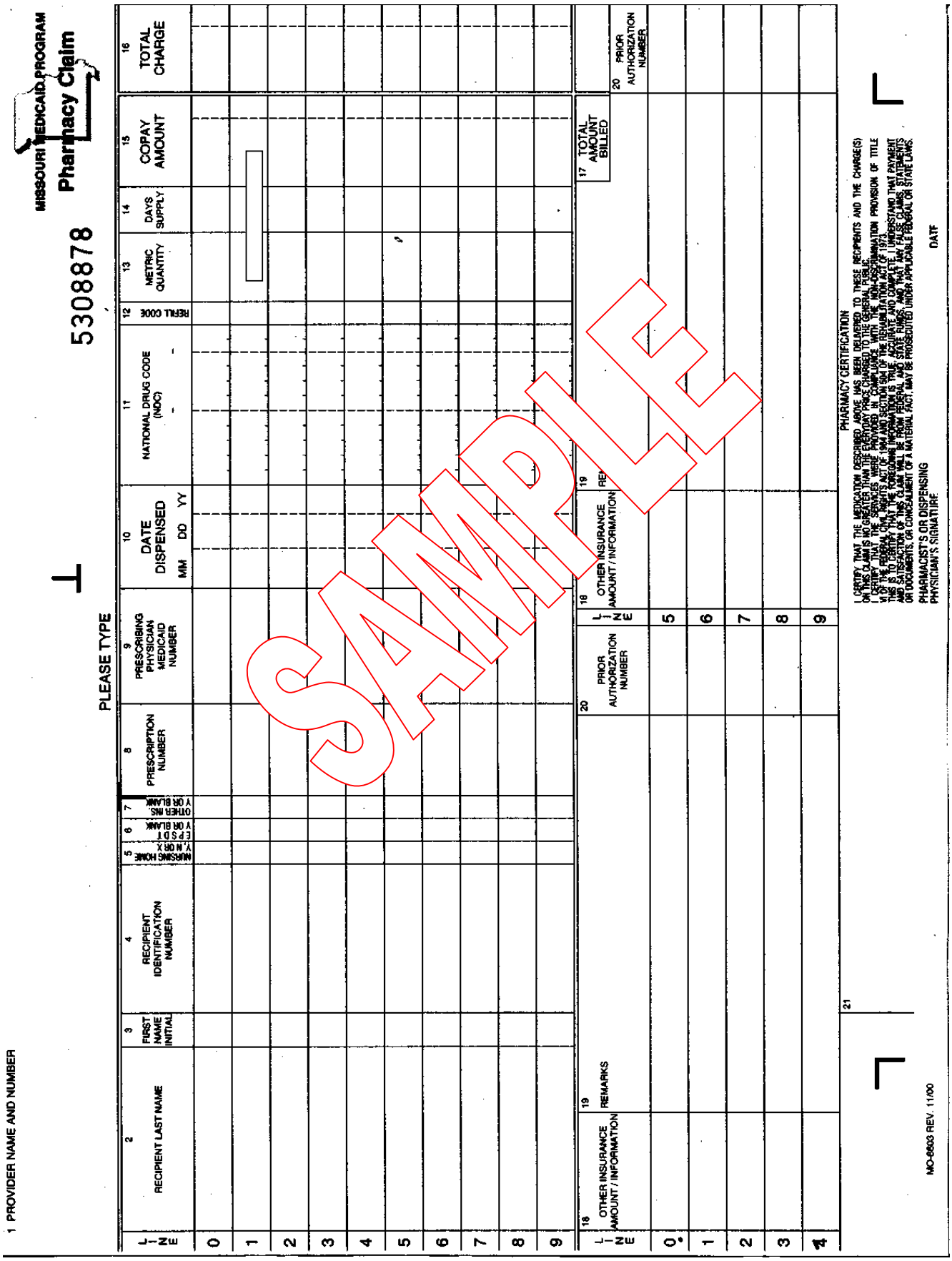
NOTE: An asterisk (*) beside field numbers indicates required fields. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.

Field Number & Name		Instructions for Completion
1.*	Provider Name and Number	Affix the preprinted provider label or enter the provider number, provider name and address *exactly* as it appears on the label.
2.*	Recipient Last Name	Enter the recipient's full last name.
3.*	First Name Initial	Enter the first letter of the recipient's first name.
4.*	Recipient Identification Number	Enter the Medicaid or MC+ number exactly as shown on the patient's ID card or approval letter.
5.	Nursing Home	Leave blank.
6.**	EPSDT	If the medication is administered as a result an EPSDT/HCY screening or referral, enter the letter "Y". Otherwise, leave blank.
7.**	Other Insurance	If the recipient has other insurance that covers injections, enter the letter "Y". Otherwise, leave blank. If "Y" is entered in this field, enter the name of insurance plan and the amount of the other insurance payment in field 18, Other Insurance Amount/Information.
8.*	Prescription Number	Enter a sequential identification number in this field. (Note: This number is used to sort claims

		submitted electronically on the remittance advice.) If the provider chooses to use a patient account number, an additional unique identifying character must be added to identify different injections administered on the same date of service. If no unique identifying character is added, all but the first claim denies as a duplicate.
9.*	Prescribing Physician	Enter the Drug Enforcement Administration (DEA) number or the Missouri Medicaid provider number for the provider performing the service. For injections given by advanced practice nurses, nurse midwives or other applicable health care professionals enter the Missouri Medicaid Provider number, or the DEA number of the collaborating physician.
10.*	Date Dispensed	Enter the date the injection was administered in MM/DD/YY numeric format.
11.*	National Drug Code	Enter the exact NDC assigned to the product administered as it appears on the package from which it was dispensed. Always enter the entire number, using the dotted lines to indicate where the hyphens appear, using the 5-4-2 format. If the drug code on the package is not in 5-4-2 format, enter zeroes in front of the numbers listed for each field. For example: NDC 45-143-20 must be listed 00045-0143-20.
12.	Refill Code.	Leave blank.
13.*	Metric Quantity	Enter the metric quantity used in administration on as follows: Products in Solution (ampule, IV bag, bottle, syringe, vial) - bill the number of cc's (ml's) administered. Vials Containing Powder for Reconstitution - bill the number of vials used. Immunizations - bill the number of doses administered. (The quantity usually equals 1). Levonorgestrel Implant - bill a quantity of 1 (1 kit = 1 unit).

14.*	Days Supply	As the process is for billing for medications administered in the physician's office, the value for this field should always equal 1. Claims with a value other than 1 in this field are denied.
15.	Co-pay Amount	Leave blank. Do not use this field to record insurance payments.
16.*	Total Charge	Enter the provider's usual and customary charge for this service.
17.*	Total Amount Billed	Enter the sum of the line items above.
18.**	Other Insurance Amount/Information	If payment from a private insurance company has been received, use the appropriate line number(s) of the claim(s) affected, enter the name of the insurance company and the amount of the insurance payment. If the insurance company denied payment for the service, use the appropriate line number(s) of the claim(s) affected, enter the name of the other insurance, and state "denial attached". Attach a copy of the insurance explanation of benefits documenting the reason for the denial. If the insurance denied the claim because their claim filing requirements were not met, Medicaid also denies the claim. See Section 5 of the Medicaid *Provider Manual* for further information about third party liability.
19.	Remarks	Leave blank.
20.	Prior Authorization Number	Leave blank.
21.	Signature	The physician or authorized representative may sign and date the form. Hand-written or computerized signatures, or a signature stamp are acceptable.

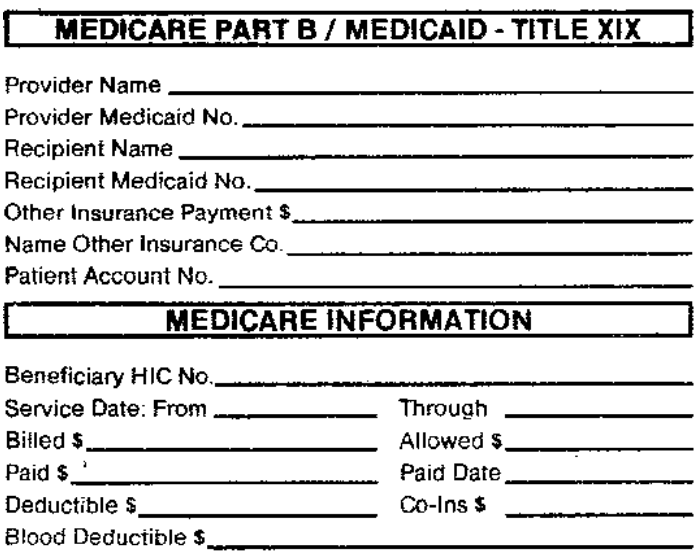
* These fields are mandatory on all Pharmacy Claim forms.
** These fields are mandatory only in specific situations, as described.


MISSOURI MEDICAID PROGRAM
Pharmacy Claim
5308878
PLEASE TYPE
1 PROVIDER NAME AND NUMBER
LINE
2 RECIPIENT LAST NAME
3 FIRST NAME INITIAL
4 RECIPIENT IDENTIFICATION NUMBER
5 NURSING HOME Y, M OR X
6 EPSDT Y OR BLANK
7 OTHER MS. Y OR BLANK
8 PRESCRIPTION NUMBER
9 PRESCRIBING PHYSICIAN MEDICAID NUMBER
10 DATE DISPENSED MM DD YY
11 NATIONAL DRUG CODE (NDC)
12 REFIL CODE
13 METRIC QUANTITY
14 DAYS SUPPLY
15 COPAY AMOUNT
16 TOTAL CHARGE
17 TOTAL AMOUNT BILLED
18 OTHER INSURANCE AMOUNT / INFORMATION
19 REMARKS
20 PRIOR AUTHORIZATION NUMBER
21
PHARMACY CERTIFICATION
I CERTIFY THAT THE MEDICATION DESCRIBED ABOVE HAS BEEN DELIVERED TO THESE RECIPIENTS AND THE CHARGE(S) ON THIS CLAIM IS NO GREATER THAN THE EVERYDAY PRICE CHARGED TO THE GENERAL PUBLIC.
I CERTIFY THAT THE SERVICES WERE PROVIDED IN COMPLIANCE WITH THE NON-DISCRIMINATION PROVISION OF TITLE VI, SECTION 504 OF THE REHABILITATION ACT OF 1973, AND THE AGE DISCRIMINATION ACT OF 1975.
I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.
PHARMACIST'S OR DISPENSING PHYSICIAN'S SIGNATURE
DATE
MO-8603 REV. 11/00
SAMPLE

SECTION 5
INSTRUCTIONS FOR COMPLETING THE MEDICARE PART B CROSSOVER STICKER

The Medicare Part B sticker should be legibly printed by hand or electronically. Complete the Medicare Part B/Medicaid-Title XIX sticker as follows and attach it to the Medicare Remittance Advice/Explanation of Medicare Benefits (RA/EOMB) so it does not cover the recipient's identifying information or claim payment information. Completed crossover claims should be mailed to:

Verizon Information Technologies
PO Box 5600
Jefferson City, MO 65102


MEDICARE PART B / MEDICAID - TITLE XIX

Provider Name _____
Provider Medicaid No. _____
Recipient Name _____
Recipient Medicaid No. _____
Other Insurance Payment $ _____
Name Other Insurance Co. _____
Patient Account No. _____

MEDICARE INFORMATION

Beneficiary HIC No. _____
Service Date: From _____ Through _____
Billed $ _____ Allowed $ _____
Paid $ _____ Paid Date _____
Deductible $ _____ Co-Ins $ _____
Blood Deductible $ _____

Field number & name		Instruction for completion
1.	Provider Name	Enter the provider's name as shown on the provider label.
2.	Provider Medicaid Number	Enter the provider's nine-digit Medicaid number.
3.	Recipient Name	Enter the patient's name exactly as shown on the ID card. (last name, first name).
4.	Recipient Medicaid Number	Enter the recipient's eight-digit identification number as shown on the ID card.

5.	Other Insurance Payment	Enter the amount paid by any other insurance or Medicare supplement.
6.	Name Other Insurance Company	If an insurance amount is shown on line 5, enter name of insurance company. If the insurance plan denied payment, enter the plan name and attach a copy of the insurance denial to the claim.
7.	Patient Account Number	For the provider's own information, a patient account number may be entered here.
8.	Beneficiary HIC Number	Enter the patient's HIC Number as shown on the Medicare card.
9. & 10.	Service Date: From and Through	Enter the date of service. If multiple dates of service are shown on the Medicare RA/EOMB for a single claim, enter the first chronological date of service in "From" field and the last chronological date of service in "Through" field.
11.	Billed	Enter the total Medicare billed amount for the claim. Use the amount shown on the Medicare RA/EOMB.
12.	Allowed	Enter the total Medicare allowed amount for the claim. Use the amount shown on the Medicare RA/EOMB.
13.	Paid	Enter the total amount paid for the claim by Medicare.
14.	Paid Date	Enter the date shown at the top of the Medicare RA/EOMB.
15.*	Deductible	If any deductible was applied on this claim, enter the amount due in this field.
16.*	Co-insurance	Enter the total amount of co-insurance due on this claim.
17.	Blood Deductible	If there is a blood deductible due, enter that amount.

* Do not enter deductible and coinsurance amounts in the same field. They must each be listed in their own field.

MEDICARE BILLING TIPS

BILLING WHEN MEDICARE HAS A DIFFERENT PATIENT NAME THAN MEDICAID

On the paper crossover sticker, show the Medicaid name first with the Medicare name in parenthesis behind it, e.g. Smith, Roberta (Bobbi) or Jones (Masters), Gerald.

CLAIMS NOT CROSSING OVER ELECTRONICALLY

If none of a provider's Medicare claims are crossing over to Medicaid electronically, contact Medicaid to see if the provider has a Medicare number on file and that it is the correct one. Although Medicare advises that a claim was forwarded to Medicaid for processing, this does not guarantee that Medicaid received the claim information or was able to process it. If there is a problem with the claim or the recipient or provider files, the claim will not process. **A provider should wait 60 days from the date a claim was paid by Medicare before filing a crossover claim with Medicaid.** If a claim is submitted sooner, it is possible that the provider will receive a duplicate payment. If this occurs, the provider must submit an Individual Adjustment Request form to have Medicaid take back one of the payments.

TIMELY FILING

Claims initially filed with Medicare within Medicare timely filing requirements and that require separate filing of a crossover claim with Medicaid must meet the timely filing requirements by being submitted by the provider and received by the Medicaid agency within 12 months from the date of service or six months from the date on the provider's Medicare Explanation of Medicare Benefits (EOMB), whichever date is *later*. The counting of the six-month period begins with the date of adjudication of the Medicare payment and ends with the date of receipt.

BILLING FOR ELIGIBLE DAYS

A provider may attempt to bill only for eligible days on the Medicaid Part B claim form. In order for crossover claims to process correctly, a provider must bill all dates of service shown on the Medicare EOMB. The Medicaid claims system will catch those days' claims containing ineligible days and the claim will be prorated for the eligible days only.

ADJUSTMENTS

If Medicare adjusts a claim and Medicaid has paid the original crossover claim, then the original claim payment from Medicaid should be adjusted using an Individual Adjustment Request form with both Medicare EOMBs attached to the form.

SECTION 6.
MEDICARE PART B CROSSOVER CLAIM REMITTANCE ADVICE (RA)

The Medicare Part B Crossover Claim Remittance Advice shows claim payment or denial of claims that either crossed over electronically from Medicare or were filed as paper crossover claims. If the claim has been denied or some other action taken affecting the payment, the RA lists an "Adjustment Reason Code" to explain the denial or other action. The Adjustment Reason Code is from a national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payor's reimbursement for it. The RA may also list a "Remittance Remark Code" which is from a national administrative code set for providing either a claim-level or service-level message that cannot be expressed with a claim Adjustment Reason Code.

If a claim is denied, a new or corrected claim form **must** be submitted as corrections **cannot** be made by submitting changes on the RA pages.

FIELD NUMBER & NAME		EXPLANATION OF FIELD
1.	Provider Number	The provider's 9-digit Missouri Medicaid number.
2.	Remittance Advice Date	The financial cycle date.
3.	Remittance Advice Number	The Remittance Advice number.
4.	Crossover Part B	The type of claim(s) processed.
5.	Page	The Remittance Advice page number.
6.	Recipient Name	The patient's last name and first name. NOTE: If the patient's name and identification number are *not* on file, only the first two letters of the last name and first letter of the first name appear.
7.	Medicaid I.D.	The patient's 8-digit Medicaid identification number (DCN).
8.	Patient Acct	The provider's own patient account name or number reported on the claim.

9.	ICN (Internal Control Number)	The number assigned to the claim for identification purposes. The first two digits of an ICN indicate the type of claim: 11--Paper Drug 15--Paper Medical 18--Paper Medicare/Medicaid Part B Crossover Claim 40--Magnetic Tape Billing (MTB) includes claims sent by Medicare intermediaries. 41--Direct Electronic Medicaid Information (DEMI) 43--MTB/DEMI 44--Direct Electronic File Transfer (DEFT) 45--Accelerated Submission and Processing (ASAP) 47--Captured Point of Service (POS) 49--Internet 50--Individual Adjustment Request 55--Mass Adjustment 70--Individual Credit to an Adjustment 75--Credit Mass Adjustment The third and fourth digits indicate the year the claim was received. The fifth, sixth, and seventh digits indicate the Julian date. In a Julian system, the days of a year are numbered consecutively from “001” (January 1) to “365” (December 31) (“366” in a leap year). The last digits of an ICN are for internal processing. The ICN number 4003275316999 is read as a Medicare electronic crossover claim that was entered in the processing system on October 2, 2003.
10.	Coinsurance	The amount of the Medicare co-insurance, if any, due on the claim.
11.	Blood Deductible	The amount of the Medicare blood deductible, if any, due on the claim.
12.	Deductible	The amount of the Medicare deductible, if any, due on the claim.
13.	From Date-Thru date	The from and thru date(s) of service reported on the claim.
14.	Other payments	Any payment reported on the claim from another source, e.g. commercial insurance.

15.	Billed Charges	The amount billed by the provider to Medicaid (e.g. co-insurance and/or deductible).
16.	Allowed Charges	The Medicaid allowed amount for the billed charge(s).
17.	Cutback	The difference between the billed amount and the allowed amount.
18.	Payment	The amount Medicaid paid on the claim.
19.	Adjust Reason Codes	Identifies the reasons for any differences, or adjustments, between the original provider billed amount for a claim or service and Medicaid's payment for it.
20.	Proc Code	The CPT or HCPCS procedure code(s) billed by the provider to Medicare.
21.	Modifiers	Procedure code modifiers reported on the claim to Medicare.
22.	Rev Code	Not applicable to professional Part B crossover claims.
23.	MCare Deduct	The Medicare deductible, if any, applied to this claim.
24.	MCare CoIns	The total amount of the Medicare co-insurance, if any, applied to this claim.
25.	MCare Paid	The amount paid by Medicare for this claim.
26.	Category Totals	Each category has separate totals for the number of claims, billed amount and allowed amount. This field also includes totals for cutback and other payments, if applicable.
27.	Number of Claims	Total claims for this provider for this claim type.
28.	Provider Totals	Totals for this provider for this RA.
29.	Number of Claims	The number of claims reported on this RA.
30.	Spenddown Amount	Total Spenddown amount(s) for this provider for this claim.

PROVIDER NUMER: 200000000 **(1)** **STATE OF MISSOURI MEDICAID** RA#1234567 **(3)**

CROSSOVER PART B **(4)** **REMITTANCE ADVICE AS OF 10-10-03 (2)** PAGE 2 **(5)**

RECIPIENT NAME **(6)** MEDICAID I.D. **(7)** PATIENT ACCT **(8)** ICN **(9)** COINSURANCE **(10)** BLOOD DEDUCTIBLE **(11)** DEDUCTIBLE **(12)**

FROM DATE-THRU DATE**(13)** OTHER PAYMENTS**(14)** BILLED CHARGES**(15)** ALLOWED CHARGE**(16)** CUT BACK**(17)** PAYMENT**(18)** ADJUST REASON CODES**(19)**

PROC CODE**(20)** M1 M2 M3 M4 **(21)** REV CODE**(22)** MCARE DEDUCT**(23)** MCARE COINS**(24)** MCARE PAID**(25)**

SMITH, BOB	98765432		X402	4003276009990	$9.03		$0.00		$0.00
07/07/03-07/07/03		$0.00		$9.03	$9.03	$0.00	$9.03 ***		
99213				000	$0.00	$9.03		$36.10	
JO, H	99922201		X0032	4003276004999	$8.00		$0.00		$0.00
04/07/03-04/07/03		$0.00		$8.00	$0.00	$8.00	$0.00	140	
69210				000	$0.00	$8.00		$32.00	
****CATEGORY TOTALS: **(26)**		$0.00		$17.03	$9.03	$8.00	$9.03***		
NUMBER OF CLAIMS= **(27)**		2							
****PROVIDER TOTALS: **(28)**		$0.00		$17.03	$9.03	$8.00	$9.03***		
NUMBER OF CLAIMS= **(29)**		2							
SPENDDOWN AMOUNT: **(30)**		$0.00							

SECTION 7.
MODIFIERS

Missouri Medicaid uses the following modifiers for the professional services.

Modifier	Description
26	Professional Component (required for laboratory, radiology, nuclear medicine/EEG/EKG services)
50	Bilateral Procedure
52	Reduced Services (for use only with EPSDT/HCY screening procedure codes and case management for pregnant women procedure code H1001TS52)
54	Surgical Care Only
55	Postoperative Management Only
59	Distinct Procedure Service (used only to identify the components of an EPSDT/HCY screen when only those components related to developmental and mental health are being screened)
62	Two surgeons
63	Procedure performed on infants (used only with CPT codes 99231-99233)
80	Assistant Surgeon
AA	Anesthesia services performed personally by anesthesiologist
EP	Service provided as part of Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT/HCY) program
QK	Medical direction of two, three or four concurrent procedures involving qualified individuals
QX	CRNA service, with medical direction by physician
QZ	CRNA service, without medical direction by physician
SL	State supplied vaccine (used only with VFC administration procedure codes for dates of service March 1, 2003 and after)
SG	Ambulatory Surgical Center (ASC) facility services
TC	Technical Component (required for laboratory and radiology services)
TG	Complex/high level of care (for use only with procedure code T1029, Environmental Lead Assessment)
TS	Follow-up Service (for use only with Case Management for Children and Youth program and for Case Management for Pregnant Women program)

The following additional level of care modifiers have been approved for use by Centers for Medicare and Medicaid Services to meet the needs of state Medicaid agencies and should not be submitted or used by any other payor.

Modifier	Description
U7	Sexual Assault Findings Examination (SAFE) and Child Abuse Resources Examination (CARE) exams
U8	Service provided in the home setting
U9	Diabetes Self-Management Training Services
UA	Lead related services
UC	EPSDT/HCY referral for follow-up care

SECTION 8.
ADJUSTMENTS

Providers who are paid incorrectly for a claim should use the *Individual Adjustment Request* form to request an adjustment. For credits only, providers may also submit individual adjustments via the Internet. Adjustments may not be requested when the net difference in payment is less than $4.00, or $.25 for pharmacy, per claim. If the adjustment is due to an insurance payment, or involves Medicare, the $4.00, or $.25, minimum limitation does not apply.

In some instances, more than one change may be necessary on a claim. **All** the changes to the claim must be addressed on the same *Individual Adjustment Request* form. Specify all the changes required, addressing each change separately. Field 15 of the form may be used to provide additional information. More than one claim **cannot** be processed per *Individual Adjustment Request* form. Each adjustment request addresses one particular claim. A separate *Individual Adjustment Request* form must be completed for each claim that requires changes, even if the changes or errors are of a similar nature or are for the same patient.

Providers submitting adjustment requests for changes in type of service codes or procedure codes must provide documentation for these changes. A copy of the original claim and the medical or operative report must be attached, along with any other information pertaining to the claim.

If an adjustment does not appear on a Remittance Advice within 90 days of submission, a copy of the original *Individual Adjustment Request* and attachments should be resubmitted. Photocopies are acceptable. Mark this copy with the word “Tracer”. Submitting another request without indicating it as a “tracer” can further delay processing. Adjustments for claim credits submitted via the Internet get a confirmation back the next day after submission to confirm the acceptance and indicate the status of the adjustment. If the Internal Control Number (ICN) on the credit adjustment is not valid, the confirmation file indicates such. If no confirmation is received, the provider should resubmit the claim credit.

See Section 4 of the Medicaid *Provider Manual* for timely filing requirements for adjustments and claim resubmissions. *Individual Adjustment Requests* form are to be submitted to the address shown on the form.

A sample Individual Adjustment Request is shown on the following page.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
MISSOURI MEDICAID

INDIVIDUAL ADJUSTMENT REQUEST

☐ UNDERPAYMENT ☑ OVERPAYMENT

TO FACILITATE PROCESSING, PLEASE ATTACH THE FOLLOWING:
1. Claim Copy
2. Remittance Advice Copy

FORWARD ORIGINAL TO:
ATTENTION: ADJUSTMENT UNIT
DIVISION OF MEDICAL SERVICES
P O BOX 6500
JEFFERSON CITY MO 65102

PLEASE ENTER THE FOLLOWING DATA FROM YOUR REMITTANCE ADVICE:

3. INTERNAL CONTROL NUMBER 1503225192499	6. RECIPIENT NAME Nelson, Harriett
4. RECIPIENT MEDICAID NUMBER 12345678	7. REMITTANCE ADVICE DATE 08/22/2003
5. PROVIDER LABEL Scott, David 200000000 486 Doctors Lane Medical City, MO 60000	8. R.A. PAGE NUMBER 7

REFER TO PROVIDER MANUAL ADJUSTMENT SECTION FOR INSTRUCTIONS

	SERVICE DATE	INFORMATION ON REMITTANCE ADVICE	CORRECTED INFORMATION
8. QTY/UNITS			
9. NDC/PROCEDURE CODE			
10. SERVICE DATE(S)			
11. BILLED AMOUNT			
12. PAID AMOUNT	08/04/2003	$24.00	$0.00
13. PATIENT SURPLUS			
14. OTHER RESOURCES (TPL) (IDENTIFY SOURCE)			

15. OTHER/REMARKS

Billed Medicaid in error. Please take back payment.

HELPFUL HINTS FOR FILING AN ADJUSTMENT REQUEST FORM

1. **Only one Internal Control Number (ICN) is allowed per adjustment request.**
2. **If you want Medicaid to recoup an entire payment, do *not* enter each line of the claim. Instead, complete the top of the form and line 12 only. Enter the date of service, the amount Medicaid paid and a "0" in the corrected information field.**
3. **When a change to a claim is necessary, such as a service date or quantity, use the ICN of the claim which paid and file an adjustment request. Do *not* send a new claim as it will deny as a duplicate.**
4. **An ICN beginning with a 70 or 75 credits or recoups the original paid claim; an ICN beginning with a 50 or 55 repays the claim with the corrected payment information.**
5. **Use the "Remarks" section of the adjustment request form to explain the reason for the correction.**

16. PROVIDER'S SIGNATURE	TITLE	DATE
		09/30/2003

MO 886-1019E (4-96) MO 8810

SECTION 9.
HEALTHY CHILDREN AND YOUTH PROGRAM

The Healthy Children and Youth (HCY) Program in Missouri is a comprehensive, primary and preventive health care program for Medicaid eligible children and youth under the age of 21 years in covered eligibility groups. The program is also known as Early Periodic Screening, Diagnosis and Treatment (EPSDT). Medicaid covers any physical or mental illness identified by the HCY screen regardless of whether the services are covered under the state Medicaid plan. Services that are beyond the scope of the Medicaid state plan may require a plan of care identifying the treatment needs of the child with regard to amount, duration, scope and prognosis. A Prior Authorization (PA) may be required for some services.

When the initial application for public assistance is made, all qualified applicants (or his/her guardian) under age 21 are informed of the HCY program. However it is advisable for providers to notify their patients when HCY screenings are due in accordance with the following periodicity schedule:

Newborn (2-3 days)	15-17 months	8-9 years
By 1 month	18-23 months	10-11 years
2-3 months	24 months	12-13 years
4-5 months	3 years	14-15 years
6-8 months	4 years	16-17 years
9-11 months	5 years	18-19 years
12-14 months	6-7 years	20 years

FULL SCREENING

A full screen must be performed by an enrolled Medicaid physician, nurse practitioner or nurse midwife *(only infants age 0-2 months and females age 15-20 years)* and must include all of the components listed below. If all of the components are not included, a provider cannot bill for a full screen and is to bill only for a partial screen.

- Interval History
- Unclothed Physical Examination
- Anticipatory Guidance
- Lab/Immunizations (Lab and administration of immunizations is reimbursed separately)
- Lead Assessment
- Development Personal-Social and Language
- Fine Motor/Gross Motor Skills
- Hearing
- Vision
- Dental

It is mandatory that the age appropriate *HCY Screening Guide* be used to document all components of a full or partial screen are met. The *HCY Screening Guide* is not

all-inclusive; it is to be used as a guide to identify areas of concern for each component of the HCY screen. Other pertinent information can be documented in the comment fields of the guide. **The screener must sign and date the guide and retain it in the patient's medical record.** *HCY Screening Guides* can be obtained by using the *Forms Request* in Section 19 of this document or by downloading from the Internet at www.dss.mo.gov/dms.

Note: A provider cannot bill for an office visit and an HCY screen on the same date of service for a patient unless documentation in the medical record indicates a medical need for the office visit. The provider must include a "Certificate of Medical Necessity" with the claim when submitting it for payment.

DIAGNOSIS CODE FOR FULL OR PARTIAL SCREEN

For service dates prior to October 16, 2003, the "EPS" diagnosis must appear as the primary diagnosis on a claim form submitted for HCY screening services. For service dates after October 16, 2003, providers must use V20.2 as the primary diagnosis on claims for HCY screening services.

FULL SCREENING PROCEDURE CODES (New Patient)

Proc. Code For Svc. Dates Prior To 10-16-03	Modifier	Proc. Code For Svc. Dates After 10-16-03 (Use Age Appropriate Code)	New Modifier 1	New Modifier 2	Fee
W0025	XC, XD	99381*	21	EP	$60.00
W0025	XC, XD	99382*	21	EP	$60.00
W0025	XC, XD	99383*	21	EP	$60.00
W0025	XC, XD	99384*	21	EP	$60.00
W0025	XC, XD	99385*	21	EP	$60.00

FULL SCREENING PROCEDURE CODES (Established Patient)

Proc. Code For Svc. Dates Prior To 10-16-03	Modifier	Proc. Code For Svc. Dates After 10-16-03 (Use Age Appropriate Code)	New Modifier 1	New Modifier 2	Fee
W0025	XC, XD	99391*	21	EP	$60.00
W0025	XC, XD	99392*	21	EP	$60.00
W0025	XC, XD	99393*	21	EP	$60.00
W0025	XC, XD	99394*	21	EP	$60.00
W0025	XC, XD	99395*	21	EP	$60.00

Modifier "UC" must be used if child was referred for further care as a result of the screening. Modifier "UC" must always appear as the last modifier.

PARTIAL SCREENING

Different providers may provide segments of the full medical screen. The purpose of this is to increase the access to care for all children and to allow providers reimbursement for those separate screens. When expanded HCY services are accessed through a partial or interperiodic screen, it is the responsibility of the provider completing the partial screening service to have a referral source to refer the child for the remaining components of a full screening service.

PARTIAL SCREENING PROCEDURE CODES – UNCLOTHED PHYSICAL & HISTORY (New Patient)

Proc. Code For Svc. Dates Prior To 10-16-03	Modifier	Proc. Code For Svc. Dates After 10-16-03 (Use Age Appropriate Code)	New Modifier 1	New Modifier 2	Fee
W0025	XI, XJ	99381*	EP		$20.00
W0025	XI, XJ	99382*	EP		$20.00
W0025	XI, XJ	99383*	EP		$20.00
W0025	XI, XJ	99384*	EP		$20.00
W0025	XI, XJ	99385*	EP		$20.00

PARTIAL SCREENING PROCEDURE CODES – UNCLOTHED PHYSICAL & HISTORY (Established Patient)

Proc. Code For Svc. Dates Prior To 10-16-03	Modifier	Proc. Code For Svc. Dates After 10-16-03 (Use Age Appropriate Code)	New Modifier 1	New Modifier 2	Fee
W0025	XI, XJ	99391*	EP		$20.00
W0025	XI, XJ	99392*	EP		$20.00
W0025	XI, XJ	99393*	EP		$20.00
W0025	XI, XJ	99394*	EP		$20.00
W0025	XI, XJ	99395*	EP		$20.00

Modifier "UC" must be used if child was referred for further care as a result of the screening. Modifier "UC" must always appear as the last modifier.

PARTIAL SCREENING CODES – DENTAL

Proc. Code For Svc. Dates Prior To 10-16-03	Modifier	Proc. Code For Svc. Dates After 10-16-03	New Modifier 1	New Modifier 2	Fee
W0025	XK	99429			$20.00
W0025	XL	99429	UC		$20.00

PARTIAL SCREENING CODES – DEVELOPMENTAL/MENTAL HEALTH

Proc. Code For Svc. Dates Prior To 10-16-03	Modifier	Proc. Code For Svc. Dates After 10-16-03	New Modifier 1	New Modifier 2	Fee
W0025	XE	99429	59		$15.00
W0025	XF	99429	59	UC	$15.00

PARTIAL SCREENING CODES – HEARING

Proc. Code For Svc. Dates Prior To 10-16-03	Modifier	Proc. Code For Svc. Dates After 10-16-03	New Modifier 1	New Modifier 2	Fee
W0025	XP	99429	EP		$5.00
W0025	XQ	99429	EP	UC	$5.00

PARTIAL SCREENING CODES – VISION

Proc. Code For Svc. Dates Prior To 10-16-03	Modifier	Proc. Code For Svc. Dates After 10-16-03	New Modifier 1	New Modifier 2	Fee
W0025	XM	99429	52		$5.00
W0025	XN	99429	52	UC	$5.00

DESCRIPTION OF MODIFIERS USED FOR HCY SCREENINGS

- **EP -** Service provided as part of Medicaid/MC+ early periodic, screening, diagnosis, and treatment (EPSDT).
- **21 -** Prolonged evaluation and management services. Modifier 21 must be used when completing a full HCY screen to include all ten components.
- **52 -** Reduced services. Modifier 52 must be used when all the components for the unclothed physical and history procedure codes (99381-99395) have not been met according to CPT. Also used with procedure code 99429 to identify that the components of a partial HCY vision screen have been met.
- **59 -** Distinct Service. Modifier 59 must be used to identify the components of an HCY screen when only those components related to developmental and mental health are being screened.
- **UC -** EPSDT Referral for Follow-Up Care. The modifier UC must be used when the child is referred on for further care as a result of the screening. The modifier UC must always appear as the last modifier on the claim.

NEWBORN EXAMINATIONS

Initial newborn examinations have been identified as HCY screenings and providers **must** use either procedure code 99431 or 99432. When billing for either of these codes, Field 24h on the CMS-1500 form **must** be marked with an "E." This indicates an EPSDT/HCY exam. The newborn's medical record must document that **the billing provider performed all components of a full HCY examination appropriate to the child's age and circumstances**.

DENTAL EXAMINATION

When a child receives a full HCY medical screen, it includes an oral examination that is **not** a full dental exam. A referral to a dental provider must be made where medically indicated when the child is under the age of one year. When the child is one year or older, a referral must be made, at a minimum, according to the dental periodicity schedule. Providers can instruct the recipient to call the toll free number on the back of their Medicaid/MC+ card to obtain a list of enrolled dental providers in their area or other areas of the state.

IMMUNIZATIONS

HCY screening providers are responsible for giving required immunizations. Immunizations are recommended in accordance with guidelines of the Advisory Committee on Immunization Practices (ACIP). Immunizations must be provided during a full medical HCY screening unless medically contraindicated or refused by the parent

or guardian of the patient. When an appropriate immunization is not provided, the patient's medical record must document why the appropriate immunization was not provided.

Providers must use the free vaccine provided by the Missouri Department of Health and Senior Services through the Vaccine for Children (VFC) program. To receive the free vaccine, providers must be enrolled with the Department of Health and Senior Services. Additional information on the VFC program appears later in this section.

LEAD SCREENING AND TREATMENT

All children ages six months to 72 months must be verbally assessed for lead poisoning using the questions contained in the *HCY Lead Risk Assessment Guide* (use Forms Request in Section 19 to order or download the Guide from the Internet at www.dss.mo.gov/dms). The *HCY Lead Risk Assessment* Guide is designed to allow the same document to follow the child for all visits from 6 months to 72 months of age. The guide has space on the reverse side to identify the type of blood test, venous or capillary, and also has space to identify the dates and results of blood lead levels. When an answer to any verbal question is "yes", a blood lead test must be done at that time.

Risk is determined from the response to the questions on the *HCY Lead Risk Assessment Guide*. The verbal risk assessment determines whether the child is low risk or high risk.

- If the answers to all questions are negative, a child is considered low risk for high doses of lead exposure.
- If the answer to any question is positive, a child is considered high risk for high doses of lead exposure and must receive a blood lead test.
- Blood level testing is mandatory at ages 12 and 24 months regardless to the response of the verbal assessment or where a child resides.

Providers must use Medicaid's *HCY Lead Risk Assessment Guide* and retain it in the patient's medical record.

For additional information on HCY/EPSDT, providers should reference Section 9 of the Medicaid *Provider Manual* at www.dss.mo.gov/dms.

PREVENTIVE MEDICINE FOR CHILDREN

Two of the key components of preventive medicine codes 99381-99395 are the history and unclothed physical examination. When an unclothed physical exam and history is performed for a recipient under the age of 21 years, providers should bill one of the appropriate HCY screening codes referenced on previous pages.

When all the components for the history and unclothed physical examination have not been met according to CPT, providers must bill one of the codes referenced in the chart below. CPT codes 99381-99395 cannot be billed alone without a modifier for a patient under the age of 21 years.

PREVENTIVE MEDICINE CODES – REDUCED- (New Patient)

Proc. Code For Svc. Dates Prior To 10-16-03	Modifier	Proc. Code For Svc. Dates After 10-16-03 (Use Age Appropriate Code)	New Modifier 1	New Modifier 2	Fee
99381		99381	52	EP	$23.00
99382		99382	52	EP	$23.00
99383		99383	52	EP	$23.00
99384		99384	52	EP	$23.00
99385		99385	52	EP	$23.00

PREVENTIVE MEDICINE CODES – REDUCED – (Established Patient)

Proc. Code For Svc. Dates Prior To 10-16-03	Modifier	Proc. Code For Svc. Dates After 10-16-03 (Use Age Appropriate Code)	New Modifier 1	New Modifier 2	Fee
99391		99391	52	EP	$15.00
99392		99392	52	EP	$15.00
99393		99393	52	EP	$15.00
99394		99394	52	EP	$15.00
99395		99395	52	EP	$15.00

SCHOOL PHYSICALS

A physical examination may be necessary in order to obtain a physician's certificate stating that a child is physically able to participate in athletic contests at school. When this is necessary, diagnosis code V20.2 should be used. This also applies for other school physicals when required as conditions for entry into or continuance in the educational process. Use the appropriate Preventive Medicine code and modifiers listed in the above tables.

SAFE/CARE EXAMINATIONS

Sexual Assault Findings Examination (SAFE) and Child Abuse Resource Education (CARE) examinations and related laboratory studies that ascertain the likelihood of sexual or physical abuse performed by SAFE trained providers certified by the Department of Health and Senior Services are covered by Medicaid. Children enrolled in a managed health care plan receive SAFE-CARE services as a benefit outside of the health plan on a fee-for-service basis. Additional information on SAFE-CARE examinations can be referenced in Section 13.15 of the physician manual located on the Internet at: www.dss.mo.gov/dms.

SAFE/CARE EXAM PROCEDURE CODES

Proc. Code For Svc. Dates Prior To 10-16-03	Modifier	Proc. Code For Svc. Dates After 10-16-03	New Modifier 1	New Modifier 2	Fee
W1350 (SAFE)		99205	U7		$187.50
W1350 (CARE)	WO	99205	U7	52	$72.50

Providers should reference Physician Manual, Section 13.15 for other procedure codes changed for SAFE/CARE related services as a result of HIPAA.

VACCINES FOR CHILDREN (VFC) PROGRAM

Through the VFC Program, federally provided vaccine is available at no charge to public and private providers for Medicaid eligible children ages 0 through 18 years.

Medicaid requires providers who administer immunizations to qualified Medicaid eligible children to enroll in the VFC program. The VFC program is administered by the Department of Health and Senior Services. Providers should contact the DOH as follows:

Missouri Department of Health and Senior Services
Section for Communicable Disease Prevention
P.O. Box 570
Jefferson City, MO 65102
(800) 219-3224, (573) 751-6133 or facsimile at (573) 526-5220

Medicaid will pay an administration fee of $5.00 per dose to providers to administer the free vaccine **except** to those providers enrolled as Rural Health Clinics (RHCs) or Federally Qualified Health Clinics (FQHCs). RHCs and FQHCs may bill an encounter code or appropriate level Evaluation and Management code if a medically necessary evaluation and management service is provided in addition to the VFC vaccine.

Immunizations for MC+ Recipients

MC+ health plans and their providers must use the VFC vaccine for Medicaid eligible MC+ health plan recipients. Plan providers must enroll in the program through the Department of Health and Senior Services. Providers should contact the appropriate MC+ health plan for proper billing procedures.

Immunizations Given Outside the VFC Guidelines

If an immunization is given to a Medicaid recipient who does not meet the VFC guidelines, use the standard procedure for billing injections. Physicians, clinics, and advanced practice nurse prescribers must bill injections on the Pharmacy Claim Form using the National Drug Code (NDC). The provider may bill either procedure code 90471 or 90472 for the administration of the immunization if that is the only service provided. If a significant, separately identifiable Evaluation and Management (E&M) service (codes 99201-99215) is performed, the appropriate E&M code may be billed in addition to the administration code.

FQHCs and provider based RHCs bill the CPT code for the appropriate immunization. Independent RHCs bill the encounter procedure code T1015 or T1015EP which includes all services provided during the encounter.

VFC ADMINISTRATION CODES

Effective for dates of service beginning March 1, 2003, providers must use the SL modifier for the following VFC administration codes.

For dates of service prior to March 1, 2003, providers must bill the administration codes with a “YG” modifier instead of the “SL” modifier.

PROCEDURE CODE	DESCRIPTION	MAXIMUM ALLOWABLE
90633SL	Administration of immunization; Hepatitis A vaccine, pediatric/adolescent dosage - 2 dose schedule, for intramuscular use	$5.00
90636SL	Hepatitis A and B, adult dosage (Twinrix)	$10.00
90645SL	Administration of immunization; Hemophilus influenza B vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use	$5.00
90647SL	Administration of immunization; Hemophilus influenza B vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use	$5.00
90648SL	Administration of immunization; Hemophilus influenza B vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use	$5.00
90655SL	Administration of immunization; influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use.	$5.00
90657SL	Administration of immunization; influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular or jet injection use	$5.00
90658SL	Administration of immunization; influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use	$5.00
90669SL	Administration of Pneumococcal; conjugate vaccine, polyvalent (Prevnar)	$5.00
90700SL	Administration of immunization; Diphtheria, Tetanus toxoids, and Acellular Pertussis vaccine (DTaP), for intramuscular use	$15.00

90702SL	Administration of immunization; Diphtheria and Tetanus toxoids (DT) adsorbed for pediatric use, for intramuscular use	$10.00
90707SL	Administration of immunization; Measles, Mumps and Rubella virus vaccine (MMR), live, for subcutaneous or jet injection use	$15.00
90713SL	Administration of immunization; Polio virus vaccine, inactivated, (IPV), for subcutaneous use	$5.00
90716SL	Administration of immunization; Varicella virus vaccine, live, for subcutaneous use	$5.00
90718SL	Administration of immunization; Tetanus and Diphtheria toxoids (Td) adsorbed for adult use, for intramuscular or jet injection	$10.00
90721SL	Administration of immunization; Diptheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DTaP-Hib), for intramuscular use	$20.00
90723SL	Diphtheria, tetanus, toxoids, acellular perussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV), for intramuscular use.	$25.00
90732SL	Administration of immunization; Pneumococcal Polysaccharide vaccine, 23-valent, adult dosage, for subcutaneous or intramuscular use	$5.00
90743SL	Administration of immunization, Hepatitis B vaccine, adolescent, muscular	$5.00
90744SL	Administration of immunization, Hepatitis B vaccine	$5.00
90748SL	Administration of immunizations, Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use, Comvax.	$10.00

SECTION 10.
MATERNITY CARE AND DELIVERY

GLOBAL POLICIES

The global prenatal/delivery/postpartum fee is reimbursable when one physician or physician group practice provides all the patient's obstetric care. For this purpose, a physician group is defined as an obstetric clinic, provider type "50", there is one patient record and each physician/nurse practioner/nurse midwife seeing that patient has access to the same patient record and makes entries into the record as services occur. A primary care physician is responsible for overseeing patient care during the patient's pregnancy, delivery and postpartum care. The clinic may elect to bill globally for all prenatal, delivery and postpartum care services provided with the clinic, using the primary care physician's provider number as the performing provider.

Global prenatal care includes all prenatal visits performed at medically appropriate intervals up to the date of delivery, routine urinalysis testing during the prenatal period, care for pregnancy related conditions (e.g. nausea, vomiting, cystitis, vaginitis) and the completion of the *Risk Appraisal for Pregnant Women* form. Only one prenatal care code, 59425 (four-six visits) or 59426 (seven or more visits) may be billed per pregnancy. The date of the delivery is the date of service to be used when billing the global prenatal codes. If a provider does more than three visits but the recipient goes to another provider for the rest of her pregnancy, all visits must be billed using the appropriate office visit procedure codes.

Billing for global services cannot be done until the date of delivery.

EXEMPTED VISITS/CONSULTATIONS

A total of two visits may be reimbursed by Medicaid to the initial provider (who is not the provider of ongoing care) to establish a pregnancy, perform an initial examination, and make a referral to a second provider. For example, many recipients utilize the services of a local health agency to establish their pregnancy which then refers them elsewhere for continuing care for their pregnancy. Therefore, if the recipient sees another provider for no more than two visits for her pregnancy, the provider of ongoing care is allowed to bill global.

In addition, two consultations may be reimbursed by Medicaid to another provider. The referring provider may still bill global.

RISK APPRAISAL - CASE MANAGEMENT

As part of the global prenatal/delivery requirements, providers must complete the *Risk Appraisal for Pregnant Women* form. No additional reimbursement will be paid for the completion of the form. Any eligible woman who meets any of the risk factors listed on the form, is eligible for case management for pregnant women services and should be referred to a Medicaid enrolled participating case management provider.

NOTE - If you are not billing any of the global prenatal/delivery codes and you complete the *Risk Appraisal for Pregnant Women* form, you may bill for completion of the form using procedure code H1000.

The risk appraisal should be done during the initial prenatal visit or any time after the initial appraisal of a patient originally determined not to be at risk when changes in the patient's medical condition indicate the need.

After completing the form, remove the top two copies and mail them to the Missouri Department of Health and Senior Services. The address is preprinted on the form and no postage is required.

Risk Appraisal for Pregnant Women forms are available from the Missouri Department of Health and Senior Services at (573) 751-6215. Ask for the Prenatal Case Manager Nursing Consultant. Send form requests to: Family Health, Prenatal Care Manager Consultant, Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102.

GLOBAL OB CODES

Code for service dates prior to 10/16/03	Previous TOS Code	Code for service dates 10/16/03 and after	Description	Medicaid Allowable
59400	2,3	59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and or forceps), and postpartum care.	$1,075.00
59510	2	59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	$1,125.00
59610	2	59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps), and post partum care, after previous cesarean delivery	$1,075.00
59618	2	59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery	$1,125.00
Y9603	2,3	59425	Antepartum care only, 4-6 visits	$525.00
Y9603	2,3	59426	Antepartum care only, 7 or more visits	$525.00

NOTE–If you are billing for service dates prior to 10/16/03, do not bill with a type of service (TOS) unless you are billing one of the electronic formats during the HIPAA grace period as outlined in the Medicaid *Physician's Bulletin* dated 9/05/03.

Billing Tip - To avoid a denial for global delivery code 59400, 59510, 59610, or 59618, if the recipient has more than two visits, you can bill the antepartum code, 59425 or 59426, plus the appropriate delivery code. If the recipient has more than two visits, only the global antepartum will be denied.

Medicaid providers have the option to bill OB services either globally or by individual dates of service. In order to bill globally, all Medicaid guidelines must be met.

OTHER DELIVERY CODES

Code for dates of service prior to 10/16-03	Previous TOS Code	Code for service dates 10/16/03 and after	Description	Medicaid Allowable
59410	2,3	59410	Vaginal delivery (with or without episiotomy, and/or forceps) including postpartum care	$550.00
59410	N	59409	Vaginal delivery only (with or without episiotomy, and/or forceps), no post partum care	$440.00
59410	D	59430	Postpartum care only (separate procedure), vaginal delivery	$110.00
59430	3	59430	Postpartum care only (separate procedure)	$110.00
59515	2	59515	Cesarean delivery including postpartum care	$600.00
59515	N	59514	Cesarean delivery only, no post partum care	$480.00
59515	D	59430	Postpartum care only (separate procedure), cesarean delivery	$110.00
--N/A--	--N/A--	59612	Vaginal delivery only, after previous cesarean delivery, (with or without episiotomy and/or forceps)	$440.00
--N/A--	--N/A--	59614	Vaginal delivery only, after previous cesarean delivery, with our without episiotomy and/or forceps), including postpartum care	$550.00
--N/A--	--N/A--	59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery.	$480.00
--N/A--	--N/A--	59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, including postpartum care	$600.00

OTHER BILLING REQUIREMENTS

- All claims with global and delivery procedure codes must show the date of the last menstrual period (LMP) in Field 14 on the CMS-1500 claim form.

- If billing a global delivery code or other delivery code, use a delivery diagnosis on the claim, e.g., 650, 669.70, etc.

- If billing a global prenatal code, 59425 or 59426, or other prenatal services, a pregnancy diagnosis, e.g., V22.0, V22.1, etc. is required on the claim.

QUESTIONS AND ANSWERS

The following are questions concerning global OB that are most frequently asked by providers and directed to the Medicaid staff.

Can Medicaid be billed by the same provider for the initial visit in the office for the pregnancy in addition to billing global?

> No, all care related to the pregnancy is included in global. The only exception would be if the patient is under the age of 21 and a Healthy Children and Youth (HCY) screen was performed at the initial visit. If this is the case, the provider may bill the HCY screen using V20.2 for the primary diagnosis and a pregnancy diagnosis for the second diagnosis. Then as long as the provider meets all other global o.b. guidelines, the global o.b. codes may be billed as well.

Can the start up of a pitocin drip be billed separately?

> No, Medicaid may not be billed for the start up of a pitocin drip. Not only is this procedure included in the global o.b. billing, it is also included in the delivery code if not billing global.

Can obstetrical ultrasounds be billed separately?

> Yes, you may bill for ultrasounds when the ultrasounds are medically necessary. Obstetrical ultrasounds are limited to three per calendar year per recipient. If more than three are necessary, the claim must be accompanied by a properly completed Medical Necessity Form documenting the necessity of the procedure. Only one ultrasound is allowed per day. If it is medically necessary to perform a repeat ultrasound on the same day, refer to the CPT for follow-up or repeat procedures.

If the Medicaid patient has received care for her pregnancy by a provider on three different occasions, can another provider still bill global if they have met all the global guidelines?

No, the recipient is allowed two visits to a provider to establish the pregnancy and obtain a referral. If more than two visits to another provider have been reimbursed by Medicaid, the provider of ongoing care must bill out all services separately, i.e., office visits, each urinalysis, hospital visits, delivery, etc.

WILL YOUR PATIENT BE IN A MC+ HEALTH PLAN?

Depending on the area of the state, it is quite possible many of your patients may be required to enroll in a MC+ health plan and choose a primary care provider. Once a patient is enrolled in a MC+ health plan, payment for covered services becomes the responsibility of the health plan. Providers are encouraged to contact health plans to become enrolled as a MC+ provider with the plans.

If a patient becomes enrolled in a MC+ health plan in her third trimester of pregnancy, she may elect to continue to receive her obstetrical services from an out-of-plan provider. The out-of-plan provider must contact the appropriate health plan for instructions. If the out-of-plan provider only has admitting privileges in an out-of-plan hospital, the health plan is obligated to negotiate with the hospital on an agreeable reimbursement schedule.

When a patient receives more than two prenatal visits in a fee-for-service setting and transitions into a MC+ health plan and changes providers, neither provider may bill for a global OB service. In this situation, both providers must bill for each date of service using the appropriate CPT code.

When the obstetrical care begins as fee-for-service and continues with the same provider into a MC+ health plan, the provider must bill for date specific services for each program (Missouri Medicaid and the MC+ health plan). The provider cannot submit a claim for global OB care to either program.

TEMPORARY MEDICAID DURING PREGNANCY (TEMP), MEDICAL ELIGIBILITY (ME) CODE 58 OR 59

The purpose of the Temporary Medicaid During Pregnancy (TEMP) Program is to provide pregnant women with access to prenatal care while they await the formal determination of Medicaid eligibility.

TEMP services for pregnant women are limited to ambulatory physician, clinic, nurse-midwife, diagnostic laboratory, x-ray, pharmacy, and outpatient hospital services. Services other than those listed above may be covered with the attachment of a *Certificate of Medical Necessity* that testifies that the pregnancy would have been adversely affected without the service.

The diagnosis on the claim form **must** be a pregnancy/prenatal diagnosis (V22.0 through V23.9 or V28 through V28.9). Nurse midwives must use diagnosis codes V22.0 through V22.2 or V28 through V28.9.

Inpatient hospital services and deliveries performed either inpatient or outpatient are *not* covered under the TEMP program. Other non-covered services include postpartum care; contraceptive management; D & C; treatment of spontaneous, missed abortions or other abortions.

Infants born to mothers who are eligible under the TEMP Program are **not** automatically eligible under this program.

ABORTIONS AND MISCARRIAGES

Missouri Medicaid does **not** cover elective abortion services.

Any claim with a diagnosis of miscarriage, or missed or spontaneous abortion, codes 632, 634.00-634.92, 635.00-635.92, 636-636.92 and 639-639.9, must be submitted on a paper CMS-1500 claim form with all appropriate documentation attached. The documentation should include the operative report, an ultrasound, the pathology report, the admit and discharge summary, etc. to show that this was not an elective abortion.

The above information is required also when submitting a claim with one of the following procedure codes: 59200, 59812, 59821, 59830, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, or 59866.

STERILIZATIONS

A Sterilization Consent form (a copy of the form is in the forms section of this publication) is a required attachment for all claims containing the following procedure codes: 55250, 58600, 58605, 58611, 58615, 58670 and 58671. **The Medicaid recipient must be at least 21 years of age at the time the consent is obtained and be mentally competent.** The recipient must have given informed consent voluntarily in accord with Federal and State requirements.

The Sterilization Consent Form must be completed and signed by the recipient at least **31** days, but not more than **180** days, prior to the date of the sterilization procedure. There must be **30** days between the date of signing and the surgery date. The day after the signing is considered the first day when counting the 30 days. There are provisions for emergency situations (reference Section 10.2.E(1) of the *Medicaid Provider Manua*l available on the internet at www.dss.mo.gov/dms).

Essure - The Essure procedure is a new permanent birth control alternative without incisions into the abdomen and any sutures or long postoperative recovery period. Essure is a device that is inserted into each fallopian tube which once incorporated into the fallopian tube, causes a localized tissue reaction. The body tissue grows into the micro-inserts, blocking the fallopian tubes.

Missouri Medicaid covers the Essure procedure in the inpatient or outpatient hospital setting only with procedure code 58615 until a specific procedure code is available. The *Sterilization Consent* form must be completed and signed at least 30 days prior to the sterilization.

SERVICES FOR WOMEN FOLLOWING THE END OF PREGNANCY-MEDICAL ELIGIBILITY (ME) CODE "80"

Services for ME "80" are limited to family planning, and testing and treatment of Sexually Transmitted Diseases (STDs) and are provided on a fee-for-service basis only. The treatments of medical complications occurring from the STD are **not** covered for this program. The co-pay requirement does not apply to ME code "80".

Covered Procedure Codes For ME "80"

Procedure Code	Description
A4260	Levonorgestrel (Norplant) (FQHC & provider-based RHC only)
A4261	Cervical cap (invoice required with claim)
A4266	Diaphragm (invoice required with claim)
J1055	Injection - Medroxyprogesterone acetate, 150 mg (FQHC & provider- based RHC only)
J7300	IUD (invoice required with claim)
J7302	Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 MG (FQHC and provider-based RHC only)
Q0111	Wet mounts (PPMP CLIA List)
T1015	Rural health clinic encounter (independent RHC)
11975	Insertion Norplant
11976	Removal Norplant
11977	Removal with reinsertion - Norplant
58300	Insertion IUD
58600	Ligation or transection of fallopian tubes
58605	Ligation or transection of fallopian tubes, postpartum
58611	Ligation or transection of fallopian tubes, at time of C-section
58615	Occlusion of fallopian tubes by device
58670	Laparoscopy with fulguration of oviducts
58671	Laparoscopy with occlusion of oviducts by device
99070	Supplies & materials over and above those usually Included with office visit
99201-99215	Evaluation and management office/outpatient procedures

Lab procedures - Pap tests, tests to identify a STD, urinalysis, and blood work related to family planning or STDs.

Medically necessary diagnostic imaging

Covered Diagnosis Codes For ME "80"

V25-V25.9	Encounter For Contraceptive Mgt
V72.3	Gynecological Exam
V73.8-V73.88	Other Specified Viral and Chlamydial Diseases
V73.9-V73.98	Unspecified Viral and Chlamydial Disease
V74.5	Venereal Disease
054.1-054.19	Genital Herpes
091-091.2, 092-092.9	Syphilis
098-098.19	Gonococcal Infections
099-099.9	Other Venereal Diseases

Covered Birth Control Products

Progestational Agents	Contraceptives, Implantable
Contraceptives, Oral	Contraceptives, Injectable

Drugs Used To Treat STDs

Keratolytics	Aminoglycosides	Penicillins	Absorbable Sulfonamides
Vaginal Antifungals	Antifungal Agents	Probenecid	Tetracyclines
Vaginal Antibiotics	Topical Antiparasitics	Macrolides	Lincosamides
Topical Antivirals	Cephalosporins	Quinolones	Antivirals, General

SECTION 11.
FAMILY PLANNING SERVICES

Family planning is defined as any medically approved diagnosis, treatment, counseling, drug, supply, or device prescribed or furnished by a provider to individuals of child-bearing age to enable such individuals to freely determine the number and spacing of their children.

When billing family planning services, providers must:

- Use a diagnosis code in the range of V25 through V25.9; and
- Enter "FP" in field 24H on the CMS-1500 or the appropriate field if billing electronically.

COVERED SERVICES

A provider may bill as a family planning service the appropriate office visit code which includes one or more of the following services.

- Obtaining a medical history
- A pelvic examination
- The preparation of smears such as a Pap Smear
  Note: Obtaining a specimen for a Pap smear is included in the office visit. Screening and interpretation of a Pap smear can be reimbursed only to a clinic or certified independent laboratory employing an approved pathologist, or to an individual pathologist.
- A breast examination
- All laboratory and x-ray services provided as part of a family planning encounter are payable as family planning services.
- A pregnancy test would be family planning related if provided at the time at which family planning services are initiated for an individual, at points after the initiation of family planning services where the patient may not have properly used the particular family planning method, or when the patient is having an unusual response to the family planning method.
- HIV blood screening testing performed as part of a package of screening testing and counseling provided to women and men in conjunction with a family planning encounter is reimbursable as a family planning service.

COPPER INTRAUTERINE DEVICE (IUD) (PARAGARD T380 – A)

The fee for procedure code 58300 covers insertion of the IUD. Procedure code J7300, Intrauterine Copper Contraceptive, should be billed for the purchase of the IUD. A copy of the invoice indicating the type and cost must be attached to the claim for manual pricing.

Code J7300 is to be used by physicians, nurse practioners, nurse midwives, federally qualified health centers (FQHCs) and provider based Rural Health Clinics (RHCs). A National Drug Code (NDC) should **not** be used to bill for the device.

The appropriate office visit procedure code may be billed for the removal of the IUD. (Procedure code 58301 is not a billable procedure as payment for the service is included in the office visit procedure code.)

LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (MIRENA)

Physicians, nurse practioners and nurse midwives must bill for the system on the Pharmacy Claim form using the National Drug Code (NDC).

FQHCs and Provider Based RHCs bill using procedure code J7302.

DIAPHRAGMS OR CERVICAL CAPS

The fitting of a diaphragm or cervical cap is included in the fee for an office visit procedure code. The cost of the diaphragm can be billed using procedure code A4266. The cost of the cervical cap can be billed using procedure code A4261. An invoice indicating the type and cost of the items must be sent with claims for these services for manual pricing.

NORPLANT SYSTEM

The following procedure codes are for insertion only, removal only, or removal with reinsertion only and do not include reimbursement for the device.

11975 - insertion, implantable contraceptive capsules
11976 - removal, implantable contraceptive capsules
11977 - removal, implantable contraceptive capsules with reinsertion

All providers except FQHCs, provider-based RHCs and hospitals (outpatient services), must bill the Norplant device on the Pharmacy Claim form using the package NDC number. FQHCs and provider-based RHCs must bill procedure code A4260 for the Norplant device.

An office visit code may not be billed in addition to any of the Norplant procedure codes.

VAGINAL RING

Physicians, nurse practioners and nurse midwives must bill for the item on the Pharmacy Claim form using the National Drug Code (NDC).

FQHCs and Provider Based RHCs bill using procedure code J7303.

DEPO-PROVERA INJECTIONS

Depo-Provera injections should be billed on the Pharmacy Claim Form using the National Drug Code (NDC). FQHCs and provider based RHCS bill the injection using the appropriate injection “J” code.

SECTION 12.
SURGERY

PROCEDURE CODES

Missouri Medicaid recognizes the CPT and HCPCS surgery procedure codes and follows the code descriptions listed in the current editions of the publications when reviewing claims. Specific knowledge of the procedures and services performed by the physician is vital in assigning the proper CPT and HCPCS codes. Systems should be in place to correctly transmit information between the physician and the coder.

SURGICAL MODIFIERS

Missouri Medicaid uses the following CPT modifiers for surgical procedures.

50 - bilateral procedure
54 - surgical care only
55 - post operative management only
62 - two surgeons
80 - assistant surgeon
SG- Ambulatory Surgical Center only (facility services)

POST-OPERATIVE CARE

Post-operative care includes 30 days of routine follow-up care for those surgical procedures having a Medicaid reimbursement amount of $75.00 or more. For counting purposes, the date of surgery is the first day.

This policy applies whether the procedure was performed in the hospital, an ambulatory surgical center or an office setting, and applies to subsequent physician visits in any setting (e.g., inpatient and outpatient hospital, office, home, nursing home, etc.).

There is no post-operative period associated with burns or endoscopy procedures.

Supplies necessary for providing follow-up care in the office, such as splints, casts and surgical dressings in connection with covered surgical procedures, may be billed under the appropriate office supply code. See Section 14 for the list of office supply codes.

INCIDENTAL/SEPARATE SURGICAL PROCEDURES

Surgeries considered incidental to, or a part of another procedure, performed on the same day, are **not** paid separately, but rather are included in the fee for the major procedure. Determine if the surgery is considered incidental by asking yourself if it is a necessary part of the surgery or was the surgery “incidentally” performed, e.g. a laparoscopy that precedes a laparotomy. For information on procedures that are not paid when incidental to other specified services, see Section 13.42 of the Medicaid *Physician Provider Manual*.

Separate procedures are defined as a service performed independently of, and is not immediately related to other services. When performed alone, for specific and documented purposes, it may be reported. The procedure should not be billed unless it is performed by itself or is not immediately related to other services being performed during the same session.

MULTIPLE SURGICAL PROCEDURES

Multiple surgical procedures performed on the same recipient, on the same date of service, by the same provider for the same or separate body systems through separate incisions are to be billed out separately for each procedure. The important factor in coding multiple surgical procedures is to list the surgeries in order of importance or significance for payment, not necessarily always listing the most time consuming procedure first. Claims for multiple surgeries are reimbursed according to the following:

100% of the allowable fee for the major procedure
50% of the allowable fee for the secondary procedure
25% of the allowable fee for the third procedure

An operative report must always accompany claims with multiple surgical procedures on the same recipient on the same date of service.

ASSISTANT SURGEON

Missouri Medicaid adheres to guidelines set by Medicare services for assistants at surgery.

Information on Medicare's guidelines for assistant surgeons is found in the Medicare Services Newsletter, "Indicators/Global Surgery Percentages/Endoscopies" at: http://www.momedicare.com/provider/provnewslet/newsindex.asp. You must accept the **License for Use of "Physicians' Current Procedural Terminology", Fourth Edition (CPT)** agreement at this website before the information can be viewed. The indicator assigned to each surgical code is found in column A of the Surgery Indicator Table.

Examples found in Column A include:

- Some procedures do not require an assistant surgeon (Assistants at surgery are never paid for these procedures.)
- Assistant at surgery is paid (No payment restriction applies.)
- Payment restriction for assistants at surgery applies; a *Certificate of Medical Necessity* form is required (These procedures do not normally require an assistant surgeon but with medical necessity will be considered for payment.)

Note - Not all codes in the listing are covered by Missouri Medicaid; refer to the Missouri Medicaid fee schedule at **www.dss.mo.gov/dms** for coverage information.

The medical necessity for the assistant at surgery must be fully documented on the C*ertificate of Medical Necessity* form. The form must include the assistant surgeon's

name, provider number, and signature. Instructions for completing the *Certificate of Medical Necessity* form are in Section 7.2 of the Missouri Medicaid *Provider Manual.*

CO-SURGERY

"Co-Surgeons" are defined as two primary surgeons working simultaneously performing distinct parts of a total surgical service, during the same operative session. Each physician should submit separate claims, using his/her own individual/clinic Medicaid provider number. The surgical procedure code together with modifier "62" should be shown on both claims. The name of both surgeons must appear on the claim form in the "description" area (field 24d on the CMS-1500), with a description of the entire (total) procedure performed. An operative report must be attached to each claim and the operative report should justify the necessity of two surgeons. These claims cannot be billed electronically and are manually priced by the medical consultant.

CONSULTATIONS

A consultation is when a physician renders an opinion or advice at the request of another physician. It is **not** a referral of a patient to another physician for care and treatment. A consultation must always include a written report sent back to the requesting physician. The written report must include all findings, the opinion of the consulting physician and advice or recommendations for patient treatment. When a consulting physician begins to "treat" rather than advise on treating, then it ceases to be a consultation. At that time, the consulting physician becomes an attending physician for the patient and should use appropriate levels of service codes based on the place of service.

CONSULTATION CODES

Office/Outpatient Consult Codes	In-patient Consult Codes
99241	99251
99242	99252
99243	99253
99244	99254
99245 (requires a copy of the consult report with the claim)	99255 (requires a copy of the consult report with the claim)

Follow-up inpatient consultations (CPT codes 99261-99263) are visits to complete the initial consultation or subsequent visits requested by the attending physician.

SECOND SURGICAL OPINION

The intent of the Second Surgical Opinion Program is to provide an eligible Missouri Medicaid patient with a second opinion as to the medical necessity of certain elective surgical operations. When the second opinion has been obtained, regardless of whether or not it confirms the primary recommendation for surgery, the final decision to undergo or forego elective surgery remains with the Medicaid patient. A list of the procedure codes requiring a second surgical opinion appears later in this section.

The Second Surgical Opinion form contains four sections and must be completed in the following manner:

Section I This section is completed by the physician recommending surgery. The appointment date in this section must be the date the patient was seen by the physician recommending surgery.

Section II Completed by the second opinion physician. A second opinion must be obtained within **60 days** after the primary recommendation appointment date in Section I of the form. When rendering a second opinion, the physician should bill a procedure code in the range of 99271-99274.

Section III Completed by the third opinion physician. A third opinion must be obtained within **60 days** after the second opinion appointment date in Section II. A third opinion is allowed by Missouri Medicaid if the second opinion fails to confirm the primary recommendation that there is a medical need for the specific surgical operation. When rendering a third opinion, the physician should bill a procedure code from the range 99271-99274.

Section IV Completed by the surgeon. Surgery must be performed within **150 days** of the first appointment date in Section I. Section IV should be completed and signed by the surgeon any time on or after the date of surgery. It is the surgeon's responsibility to furnish the hospital or ambulatory surgical center with a copy of the completed second opinion form.

Staff interns, residents and nurse practioners are **not** permitted to provide the first, second or third opinion.

Note – Anesthesiologists, assistant surgeons, independent laboratories, and independent x-ray services are exempt from the requirement to submit a copy of the Second Surgical Opinion form with a claim for services.

EXCEPTIONS TO SECOND OPINION REQUIREMENT

- Medicare/Medicaid crossover claims are exempt.
- The Second Surgical Opinion form is not required if the surgeon does not participate in the Missouri Medicaid Physician Program. This must be stated in field 19 of the CMS-1500 claim form and the physician's full name listed.
- Those surgical operations specified are exempt from the second surgical opinion requirement if any one of them is performed incidental to a more major surgical procedure that does not require a second surgical opinion.

- If the service was performed as an emergency and a second opinion could not be obtained prior to rendering the service, complete the claim form and enter "emergency" in field 19 of the CMS-1500. Attach a *Certificate of Medical Necessity* form (or other adequate documentation such as operative notes, admit or discharge summaries, etc.) to the claim. The provider must state on the *Certificate of Medical Necessity* form, in detail, the reason for the emergency provision of service.

- If the recipient was not eligible for Medicaid at the time of service, but was made retroactive to that time. If the provider is unable to obtain an eligibility approval letter from the recipient, the claim may be submitted with a completed *Certificate of Medical Necessity* form indicating the recipient was not eligible at the time of service but has become eligible retroactively to that date. (See Section 7 of the Missouri *Medicaid Provider* Manual for information on completing the *Certificate of Medical Necessity* form.) If the eligibility approval letter or the *Certificate of Medical Necessity* form is not submitted, the claim will be denied.

SURGERY CODES THAT REQUIRE A SECOND OPINION

The following procedure codes require a second surgical opinion and the submission of a Second Surgical Opinion" form. Procedure codes marked with an asterisk (*) also require the submission of an "Acknowledgment of Hysterectomy Information" form.

28290	49491-50	49570	58240*	58953-62*	63042-62
28290-50	49491-62	46570-50	58240-62*	58954*	63042-6250
28292	49491-6250	49570-62	58260*	58954-62*	63045
28292-50	49495	49570-6250	58260-62*	59525*	63045-62
28292-62	49495-50	49580	58262*	59525-62*	63046
28292-6250	49495-62	49580-62	58262-62*	63001	63046-62
28293	49495-6250	49585	58263*	63001-62	63047
28293-50	49500	49585-62	58263-62*	63003	63047-62
28293-62	49500-50	49650	58267*	63003-62	63048
28293-6250	49500-62	49650-50	58267-62*	63005	63048-62
28296	49500-6250	49650-62	58270*	63005-62	63055
28296-50	49505	49650-6250	58270-62*	63011	63055-62
28296-62	49505-50	49651	58275*	63011-62	63056
28296-6250	49505-62	49651-50	58275-62*	63012	63056-62
28297	49505-6250	49651-62	58280*	63012-62	63057
28297-50	49520	49651-6250	58280-62*	63015	63057-62
28297-62	49520-50	49659	58285*	63015-62	63064
28297-6250	49520-62	49659-50	58285-62*	63016	63064-62
28306	49520-6250	51925*	58290*	63016-62	63066
28306-62	49525	51925-62*	58290-62*	63017	63066-62
28308	49525-50	57240	58291*	63017-62	63075
28308-62	49525-62	57240-62	58291-62*	63020	63075-62
47562	49525-6250	57250	58292*	63020-50	63076
47562-62	49550	57250-62	58292-62*	63020-62	63076-62
47563	49550-50	57260	58293*	63020-6250	63077
47563-62	49550-62	57260-62	58293-62*	63030	63077-62
47564	49550-6250	57265	58294*	63030-50	63078
47564-62	49555	58265-62	58294-62*	63030-62	63078-62
47600	49555-50	58120	58550*	63030-6250	63081
47600-62	49555-62	58150*	58550-62*	63035	63081-62
47605	49555-6250	58150-62*	58552*	63035-50	63082
47605-62	49560	58152*	58552-62*	63035-62	63082-62
47610	49560-50	58152-62*	58553*	63035-6250	63085
47610-62	49560-62	58180*	58553-62*	63040	63085-62
47612	49560-6250	58180-62*	58554*	63040-50	63086
47612-62	49565	58200*	58554-62*	63040-62	63086-62
47620	49565-50	58200-62*	58951*	63040-6250	63087
47620-62	49565-62	58210*	58951-62*	63042	63087-62
49491	49565-6250	58210-62*	58953*	63042-50	63088

63088-62	63185	63194-62	63199	66852-6250
63090	63185-62	63195	63199-62	66920
63090-62	63190	63195-62	66840	66920-50
63091	63190-62	63196	66840-50	66920-62
63091-62	63191	63196-62	66850	66920-6250
63180	63191-50	63197	66850-50	66983
63180-62	63191-62	63197-62	66852	66983-50
63182	63191-6250	63198	66852-50	66984
63182-62	63194	63198-62	66852-62	66984-50

SECTION 13. ANESTHESIA

PROCEDURE CODES

Medicaid recognizes CPT anesthesia codes 00100 - 01999. The surgical procedure for which anesthesia services are being provided, must be a covered Medicaid service.

When the anesthesiologist or CRNA administers anesthesia for multiple surgical procedures for the same recipient on the same date of service during the same surgery, only the major procedure should be billed and the total number of minutes should be shown for all procedures.

Physicians and CRNAs may also bill for the insertion of intra-arterial lines, Swan Ganz catheters, central venous pressure lines, emergency intubation, and epidurals. These services are separately reportable when performed by the physician or CRNA using the following procedure codes. These codes should be billed **without** any modifiers.

20550	36406	36510	62282	64408	64421	64510
31500	36410	36600	62310	64410	64425	64520
36000	36420	36620	62311	64412	64430	64530
36010	36425	36625	62318	64413	64435	93503
36011	36488	36660	62319	64415	64445	99100
36014	36489	36680	64400	64417	64450	99116
36400	36490	62273	64402	64418	64505	99135
36405	36491	62281	64405	64420	64508	99140

SUPERVISION (MEDICAL DIRECTION)

Anesthesiologists must have a provider specialty of anesthesiology to bill for medical direction of qualified and licensed Anesthesiologist Assistants (AA) and CRNAs.

Anesthesiologists must supervise at least two, but not more than four anesthetists. When the anesthesiologist and anesthetist both are involved in a single anesthesia service (supervision of only one anesthetist), the service is considered to be personally performed by the anesthesiologist. No separate payment is allowed for the CRNA and a charge for supervision is inappropriate.

MODIFIERS

The following modifiers should be used for anesthesia services.

AA - Anesthesia services performed personally by anesthesiologist
QK - Medical direction of two, three or four concurrent procedures involving qualified individuals
QX - CRNA service, with medical direction by physician
QZ - CRNA service, without medical direction by physician

ANESTHESISA BILLING TIPS

- For paper claims with dates of service **prior** to October 16, 2003, bill the surgical procedure code with the appropriate modifier (AA, QK, QX or QZ) for the service. Do **not** use a type of service code.
- Administration of local infiltration, digital block, or topical anesthesia by the operating surgeon or obstetrician is included in the surgery fee, and a separate fee for administration should not be billed.
- Local anesthesia should not be reported separately. It is included in the procedure/surgery if provided in the physician's office; if provided in an Ambulatory Surgical Center (ASC) or outpatient department of the hospital, it is included in the facility charge; if provided on an inpatient basis, it is included in the accommodation revenue code for the facility.
- There may be an occasional need for anesthesia during CT scan or MRI services as a result of medically necessary circumstances, i.e., hyperactive child, mentally retarded individual, etc. To report this service, use procedure code 01922 (unlisted diagnostic radiologic procedure) with the appropriate modifier.
- Anesthesiologist monitoring telemetry in the operating room is non-covered.
- Routine resuscitation of newborn infants is included in the fee for the administration of the obstetrical anesthesia in low-risk patients.
- Anesthesiologist and CRNA services are not covered in the recovery room.
- Pain management is considered a part of postoperative care. However, if an epidural or intrathecal catheter is specifically inserted for pain management, it can be reimbursed. If already inserted for anesthesia, no separate payment is allowed.
- Many anesthesia services are provided under particularly difficult circumstances, depending on factors such as extraordinary condition of patient, notable operative conditions, or unusual risk factors. These procedures may be reported in addition to anesthesia services. The following procedures should be billed:

  99100 - Anesthesia for patient of extreme age, under one year and over seventy.
  99116 - Anesthesia complicated by utilization of total body hypothermia.
  99135 - Anesthesia complicated by utilization of controlled hypotension.
  99140 - Anesthesia complicated by emergency conditions (specify).

  When billing the above procedure codes, the maximum quantity is always "1" as reimbursement is based on a fixed maximum allowable amount.

SECTION 14.
OFFICE MEDICAL SUPPLY CODES

Supplies and materials provided by the physician above those usually included with an office visit may be billed using the appropriate supply code.

PROC. CODE	DESCRIPTION
A4260	Levonorgestrel (Norplant) device only (FQHC and provider-based RHC only)
A4261	Cervical Cap for Contraceptive use (invoice required for pricing)
A4266	Diaphragm (invoice required for pricing)
A4300	Implantable Vascular Access Portal/Catheter (Venous, Arterial, Epidural or Peritoneal)
A4344	Indwelling Catheter, Foley Type, Two-Way, All Silicone
A4565	Slings
A4570	Splint
A4580	Cast Supplies
A4590	Casting (Fiberglass)
A4627EP	Spacer, Bag or Reservoir, with or without mask, for use with metered dose inhaler (invoice required for pricing)
J7300	Intrauterine Copper Contraceptive (Invoice required for pricing)
J7302	Levonorgestrel-Releasing Intrauterine Contraceptive System (Mirena) (for FQHC and provider-based RHC use only)
J7303	Vaginal Ring (for FQHC and provider-based RHC use only)
L0120	Cervical, Flexible, Non-Adjustable (Foam Collar)
L0140	Cervical, Semi-Rigid, Adjustable (Plastic Collar)
L1825	KO, Elastic Knee Cap
99070	Supplies and material (except eyeglasses, hearing aids) provided by the physician over and above those usually included with the office visit or other services rendered. (In Field 24D of the CMS-1500 claim form, list drugs, trays, supplies or materials provided.) (Invoice required for pricing)

SECTION 15.
PRIOR AUTHORIZATION

Providers are required to seek prior authorization for certain specified services **before** delivery of the services. In addition to services that are available through the traditional Medicaid Program, expanded services are available to children 20 years of age and under through the Healthy Children and Youth (HCY) Program. Some expanded services also require prior authorization.

The following general guidelines pertain to all prior authorized services.

- A Prior Authorization (PA) Request (yellow form) **must** be completed and mailed to: Verizon, P.O. Box 5700, Jefferson City, M0 65102. Providers should keep a copy of the original PA Request form, as the form is not returned to the provider.
- The provider performing the service **must** submit the PA Request form. Sufficient documentation or information **must** be included with the request to determine the medical necessity of the service.
- The service **must** be ordered by a physician, nurse practitioner, dentist, or other appropriate health care provider.
- Do **not** request prior authorization for services to be provided to an ineligible person. Authorization considers medical necessity only and does not examine eligibility.
- Expanded HCY (EPSDT) services are limited to recipients 20 years of age and under and are **not** reimbursed for recipients 21 and over even if prior authorized.
- Prior authorization does **not** guarantee payment if the recipient is or becomes enrolled in managed care and the service is a covered benefit.
- Payment is **not** made for services initiated before the approval date on the PA Request form or after the authorization deadline. For services to continue after the expiration date of an existing PA Request, a new PA Request **must** be completed and mailed.

Whether the prior authorization is approved or denied, a disposition letter will be returned to the provider containing all of the detail information related to the prior authorization request. Any other documentation submitted with the prior authorization request will not be returned with the exception of x-rays and dental molds. All requests for changes to an approved prior authorization should be indicated on the disposition letter and submitted to the same address as the original prior authorization request.

Instructions for completing the PA Request form are found in Section 8 of the Medicaid *Provider's Manual* available on the Internet at www.dss.mo.gov/dms.

PROCEDURES REQUIRING A PRIOR AUTHORIATION

The following procedure codes require a Prior Authorization Request form.

11920	15833	19357	21122	43847-62	67900
11920-EP	15834	19357-50	21123	43848	67901
11921	15835	19361	21123-62	43848-62	67901-50
11921-EP	15836	19361-50	21125	50365	67902
11922-EP	15837	19364	21127	50365-50	67902-50
11960	15838	19364-50	21127-62	50365-62	67902-62
11970	15839	19366	21188	50365-6250	67902-6250
11971	17999-EP	19366-50	21194	50547	67903
11981	19316	19367	21230	50547-50	67903-50
11982	19316-50	19367-50	21235	50547-62	67903-62
11983	19318	19368	21260	50547-6250	67903-6250
15780	19318-50	19368-50	21260-62	54152	67904
15781	19324	19369	21261	54161	67904-50
15782	19324-50	19369-50	21261-62	54162	67904-62
15786	19325	19370	21720	54163	67904-6250
15787	19325-50	19370-50	21725	54164	67906
15810	19328	19371	21725-62	56805	67906-50
15811	19328-50	19371-50	26580	56805-62	67908
15820	19330	19380	26590	57335	67908-50
15820-50	19330-50	19380-50	43659	57335-62	67909
15821	19340	20974	43659-50	58345	67909-50
15821-50	19340-50	21086	43842	58345-50	67923
15822	19342	21086-50	43842-62	58345-62	67923-50
15822-50	19342-50	21087	43843	58345-6250	67924
15823	19350	21088	43843-62	65767	67924-50
15823-50	19350-50	21120	43846	65767-50	69300
15831	19355	21120-62	43846-62	65780	69949-EP
15832	19355-50	21121	43847	65782	92391-EP

SECTION 16.
LABORATORY SERVICES

Missouri Medicaid follows Medicare guidelines for billing of professional and technical and total components of laboratory tests. Providers should reference Medicare's Newsletter for Indicators/Global Surgery/Percentages/Endoscopies at http://www.momedicare.com/.

Professional component only codes – Modifiers 26 and TC cannot be used with these codes. Examples - 80500 and 85097.

Technical component only codes – Modifiers 26 and TC cannot be used with these codes. Examples – 81002 and 82270.

Total component codes – These codes have a professional, technical and total component. When billing for the professional component, use the 26 modifier. When billing for the technical component, use the TC modifier. When billing for the total component, do not use any modifiers. Examples - 88104, 88300.

Clinical Laboratory Improvement Act (CLIA)

CLIA WAIVER PROCEDURES

Medicaid providers possessing a "Certificate of Waiver" are allowed to perform the following procedures.

G0328	82270	83001	85013	87210
80061	82273	83002	85014	87210U7
80101	82274	83026	85018	87449
81002	82465	83036	85610	87804
81003	82570	83518	85651	87880
81007	82679	83605	86294	87899
81025	82947	83718	86308	89300
81025U7	82950	83986	86318	
82010	82951	84460	86618	
82044	82952	84478	86701	
82055	82962	84703	87072	
82120	82985	84830	87077	

PHYSICIAN PERFORMED MICROSCOPY PROCEDURES (PPMP)

Medicaid providers possessing a PPMP certificate are allowed to perform all the waiver procedures as well as the following additional procedures.

Q0111	Q0113	Q0115	81001	81020
Q0112	Q0114	81000	81015	89190

Questions regarding CLIA registration or accreditation should be directed to:

Bureau of Health Facility Regulation
Department of Health and Senior Services
P.O. Box 570
Jefferson City, Missouri 65102-0570
(573) 751-6318

SECTION 17.
RESOURCE PUBLICATIONS FOR PROVIDERS

CURRENT PROCEDURE TERMINOLOGY (CPT)

Missouri Medicaid uses the latest version of the *Current Procedural Terminology* (CPT). All provider offices should obtain and refer to the CPT book to assure proper coding. Providers can order a CPT book from the American Medical Association.

Order Department
American Medical Association
PO Box 7046
Dover, DE 19903-7046
Telephone Number: 800/621-8335
Fax Orders: 312/464-5600

ICD-9-CM

The *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9) is the publication used for proper diagnostic coding. The diagnosis code is a required field on certain claim forms and the accuracy of the code that describes the patient's condition is important. The publication can be ordered from the following source.

Ingenix Publications
PO Box 27116
Salt Lake City, UT 84127-0116
800/464-3649
Fax Orders: 801/982-4033
www.IngenixOnline.com

HEALTH CARE PROCEDURE CODING SYSTEM (HCPCS)

Medicaid also uses the *Health Care Procedure Coding System (HCPCS), National Level II*. It is a listing of codes and descriptive terminology used for reporting the provision of supplies, materials, injections and certain services and procedures. The publication can be ordered from the following.

Practice Management Information Corporation
4727 Wilshire Blvd. Ste 300
Los Angles, CA 90010
800/633-7467
http://pmiconline.com

SECTION 18.
RECIPIENT LIABILITY
State Regulation 13CSR 70-4.030

If an enrolled Medicaid provider does not want to accept Missouri Medicaid as payment but instead wants the patient (recipient) to be responsible for the payment (be a private pay patient), there must be a written agreement between the patient and the provider in which the patient understands and agrees that Medicaid will not be billed for the service(s) and that the patient is fully responsible for the payment for the service(s). The written agreement must be date and service specific and signed and dated both by the patient and the provider. **The agreement must be done prior to the service(s) being rendered.** A copy of the agreement must be kept in the patient's medical record.

If there is no evidence of this written agreement, the provider cannot bill the patient and must submit a claim to Medicaid for reimbursement for the covered service(s).

If Medicaid denies payment for a service because all policies, rules and regulations of the Missouri Medicaid program were not followed (e.g., Prior Authorization, Second Surgical Opinion, etc.), the patient is not responsible and cannot be billed for the item or service.

All commercial insurance benefits must be obtained before Medicaid is billed.

MEDICAID RECIPIENT REIMBURSEMENT (MMR)

The Medicaid Recipient Reimbursement program (MMR) is devised to make payment to those recipients whose eligibility for Medicaid benefits has been denied and whose eligibility is subsequently established as a result of an agency hearing decision, a court decision based on an agency hearing decision, or any other legal agency decision rendered on or after January 1, 1986.

Recipients are reimbursed for the payments they made to providers for medical services received between the date of their denial and the date of their subsequent establishment of eligibility. The recipient is furnished with special forms to have completed by the provider(s) of service. If Medicaid recipients have any questions, they should call (800) 392-2161.

SECTION 19.
FORMS

On the following pages are copies of various forms used by the Missouri Medicaid program.

Certain Medicaid programs, services and supplies require the submission of a form before a claim can be processed for payment. Please note that several of the forms can be submitted electronically through the Verizon Internet service at www.emomed.com.

Acknowledgement of Receipt of Hysterectomy Information
Second Surgical Opinion
Sterilization Consent

If a form is submitted electronically, the provider **must** keep a paper copy of the form in the patient's medical record.

Copies of the forms are available from Medicaid from the following sources.

- Contact the Provider Communications Unit at 800/392-0938 or 573/751-2896.
- Go to the Medicaid website, www.dss.mo.gov/dms, and select and click on the link to the Missouri Medicaid Provider Manuals.
- Use the Verizon order form found at the end of this section.

MO-8812

CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE.** I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____ (Month Day Year)

I, _____, hereby consent

of my own free will to be sterilized by _____ (doctor)

by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Date _____
Signature (Month Day Year)

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ _____
Interpreter Date

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____ _____
Signature of person obtaining consent *Date*

_____
Facility

_____
Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____ (Name of individual to be sterilized), _____ (Medicaid number), on _____ (Date of sterilization), I explained to him/her the nature of the sterilization operation _____ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Gross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested).

- ☐ Premature delivery
- ☐ Individual's expected date of delivery:
- ☐ Emergency abdominal surgery:

(describe circumstances):

_____
Physician

_____ _____
Medicaid provider number *Date*

PSFL - 200
(Revised 11/01/00)

MISSOURI DEPARTMENT OF HEALTH

RISK APPRAISAL FOR PREGNANT WOMEN

INSTRUCTIONS ON REVERSE SIDE

DCN OR TEMP. NO	BIRTHDATE (MM/DD/YY)	DATE OF RISK APPRAISAL	PROVIDER NAME (ATTACH MEDICAID PROVIDER LABEL)
CLIENT'S NAME (LAST, FIRST, MI, MAIDEN)			ADDRESS (STREET)
ADDRESS (STREET)			CITY STATE ZIP CODE
CITY STATE ZIP CODE			MEDICAID PROVIDER NUMBER
TELEPHONE NUMBER ( )	COUNTY OF RESIDENCE		MARITAL STATUS CODE ☐ S ☐ M ☐ W ☐ D ☐ SEP

MONTH PRENATAL CARE BEGAN ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9

RACE/ETHNICITY	HISPANIC ORIGIN	LMP (MM/DD/YY)	GRAVIDA	PARA	ABORTA
☐ 1. WHITE ☐ 2. BLACK ☐ 3. AM.IND/ALASKAN ☐ 4. ASIAN/PACIFIC ISLANDER ☐ 5. OTHER _____	☐ YES ☐ NO				

PUT AN "X" IN ALL THE BOXES BELOW THAT APPLY. AN "X" IN ANY ONE OF THE FIRST 34 RISK FACTOR BOXES QUALIFIES CLIENT FOR CASE MANAGEMENT SERVICES.

☐ 1. Mother's age 17 years of less at time of conception.

☐ 2. Mother's education less than 8 years.

☐ 3. Gravida greater than or equal to 7.

☐ 4. Smoking equal to or greater than one pack of cigarettes per day, IF CLIENT HAS STOPPED SMOKING BY THE 12TH WEEK OF GESTATION, CONSIDER AS NON SMOKING.

☐ 5. Mother's age 40 years or greater at time of conception.

☐ 6. Prepregnancy weight less than 100 lbs.

☐ 7. Previous fetal death (20 weeks gestation or later).

☐ 8. Previous infant death.

☐ 9. History of incompetent cervix in current or past pregnancy.

☐10. History of diabetes mellitus including gestational diabetes in current or past pregnancy.

☐11. Multiple fetuses in current pregnancy.

☐12. Pre-existing hypertension (a history of hypertension — 140/90 mm Hg or greater — antedating pregnancy or discovery of hypertension — 140/90 or greater — before the 20th week of pregnancy).

☐13. Pregnancy-induced hypertension in current pregnancy (blood pressure is 140/90 or greater, or there has been an increase of 30 mm Hg systolic or 15 mm Hg diastolic over baseline values on at least two occasions six or more hours apart).

☐14. Prior low birth weight baby (<2500 grams or 5 lbs. 8 oz.).

☐15. Prior preterm labor (<37 completed weeks gestation).

☐16. Preterm labor: current pregnancy.

☐17. Seropositive for HIV antibodies.

☐18. Interconceptional spacing <1 year.

☐19. Living alone or single parent living alone.

☐20. Considered relinquishment of infant.

☐21. Poor environmental conditions.

☐22. Late entry into care (after 4th month or 18 weeks gestation).

☐23. Homelessness.

☐24. Alcohol abuse by client.

☐25. Alcohol abuse by partner.

☐26. Drug dependence or misuse by client.

☐27. Drug dependence or misuse by partner.

☐28. Physical or emotional abuse/neglect of client.

☐29. Physical abuse of children in the home.

☐30. Neglect of children in the home.

☐31. Partner with history of violence.

☐32. Chronic or recent mental illness and/or psychiatric treatment.

☐33. Elevated blood lead level 15ug/dl or greater.

☐34. Other, identify: _____

_____

☐99. None of the above.

FOLLOWING DOES NOT QUALIFY FOR CASE MANAGEMENT SERVICES. DATA COLLECTION IS NECESSARY FOR PROGRAM PLANNING. (CHECK ONE)

☐ 1. Intended pregnancy.
☐ 2. Unintended pregnancy using birth control
☐ 3. Unintended pregnancy not using birth control.
☐ 4. Unintended pregnancy - birth control unknown.

SPECIFY GESTATIONAL AGE AT TIME OF RISK APPRAISAL: WEEKS	APPROXIMATE DUE DATE MM DD YY	PHYSICIAN'S PERFORMING PROVIDER NUMBER
PROVIDER SIGNATURE ▶		DATE
PREFERRED CASE MANAGEMENT PROVIDER AGENCY		

MO 580-1171 (9-97) **DISTRIBUTION:** **WHITE/CANARY** - BSHCN/CASE MANAGEMENT AT TIME OF ENTRY **GREEN** - CLIENT **PINK** - CLIENT'S RECORD CM-4

MISSOURI MEDICAID
CERTIFICATE OF MEDICAL NECESSITY

	Patient Name			Medicaid ID Number	
	TOS	Procedure Codes (Maximum 6)	Description of Item/Service	Reason for Service	Months Equip. Needed (DME only):
1.					
2.					
3.					
4.					
5.					
6.					

Attending/Prescribing Physician Name		Attending/Prescribing Physician Medicaid Number
Date Prescribed	Diagnosis	Prognosis
Provider Name and Address		Provider Medicaid Number
Provider Signature		

MO-8813 PLEASE SUBMIT THIS FORM FOR EACH PROCEDURE REQUIRING DOCUMENTATION OF MEDICAL NECESSITY DS1960 (09/01/02)

40

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
EXCEPTIONS UNIT

MEDICAID EXCEPTION REQUEST

RETURN TO: ATTN EXCEPTIONS UNIT
DIVISION OF MEDICAL SERVICES
PO BOX 6500
JEFFERSON CITY MO 65102-6500
FAX NO: 573-522-3061

ALL INFORMATION MUST BE SUPPLIED OR THE REQUEST WILL BE RETURNED

FOR LIFE THREATENING EMERGENCIES
CALL 1-800-392-8030

PLEASE TYPE OR PRINT

RECIPIENT NAME	DATE OF BIRTH

RECIPIENT MEDICAID NUMBER (DCN)	SOCIAL SECURITY NUMBER

RECIPIENT DIAGNOSES (MUST RELATE TO ITEM(S) OR SERVICE(S) REQUESTED)

LIST ALL APPROPRIATE ALTERNATIVE COVERED SERVICES ATTEMPTED AND FOUND INEFFECTIVE FOR THIS DIAGNOSIS.

REQUESTED ITEM(S) OR SERVICE(S) (INCLUDING DAILY QUANTITY)

DURATION OF NEED

MISSOURI MEDICAID PROVIDER WHO WILL BE DISPENSING AND BILLING FOR SERVICES (EX. DME PROVIDER)

NAME	TELEPHONE NUMBER
ADDRESS	PROVIDER NUMBER (IF KNOWN)
IS A HOME HEALTH AGENCY MAKING SKILLED NURSE VISITS? ☐ YES ☐ NO	AGENCY NAME
PRINT OR TYPE DOCTOR'S NAME OR ADVANCED PRACTICE NURSE'S (APN) NAME AND TITLE	TELEPHONE NUMBER
PRINT OR TYPE DOCTOR'S ADDRESS OR APN'S ADDRESS	FAX NUMBER
DOCTOR'S ORIGINAL SIGNATURE, OR APN'S ORIGINAL SIGNATURE AND TITLE (NO STAMPS OR PHOTOCOPIES) ▶	DATE

MO 886-3351 (3-02)

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

TPL-4

MISSOURI MEDICAID INSURANCE RESOURCE REPORT

Submit this form to notify the Medicaid agency of insurance information that you have verified for a Medicaid recipient. Please send the completed form to:

Department of Social Services
Division of Medical Services
Attention: TPL Unit
P.O. Box 6500
Jefferson City, MO 65102-6500

DO NOT SEND CLAIMS WITH THIS FORM. YOUR CLAIM WILL NOT BE PROCESSED FOR PAYMENT IF ATTACHED TO THIS FORM.

PROVIDER IDENTIFICATION NUMBER	DATE (MM / DD / YY)
___ ___ ___ ___ ___ ___ ___ ___ ___	

PROVIDER NAME

CHECK THE APPROPRIATE BOX FOR THE REQUESTED ACTION

☐ ADD NEW RESOURCE OR ☐ CHANGE MEDICAID RESOURCE FILES

RECIPIENT NAME	MEDICAID I.D. NUMBER
	___ ___ ___ ___ ___ ___ ___ ___

INSURANCE COMPANY NAME

POLICYHOLDER (IF OTHER THAN RECIPIENT)	POLICYHOLDER'S SOCIAL SECURITY NUMBER

POLICY NUMBER	GROUP NAME OR NUMBER

VERIFIED INFORMATION

_____

_____

SOURCE OF VERIFIED INFORMATION: ☐ EMPLOYER ☐ INSURANCE COMPANY

TELEPHONE NUMBER OF CONTACT	DATE CONTACTED (MM / DD / YY)
( )	

NAME OF PERSON COMPLETING THIS FORM	TELEPHONE NUMBER

Do you want confirmation of this add/update?
(If yes, you **must** complete the name and address on back) ☐ YES ☐ NO

ATTACH A COPY OF AN EXPLANATION OF BENEFITS OR INSURANCE LETTER IF AVAILABLE

MO 886-2983 (2-97)

TO BE COMPLETED BY THE PROVIDER

If confirmation of this add/update is requested, please write the name and address of the person the confirmation should be sent to below. The TPL Unit will complete the bottom portion of this form and mail to the address shown.

_____

_____

_____

TO BE COMPLETED BY THE STATE

❑ Verification and correction as requested completed Date: _____

Insurance Begin Date: _____ Insurance End Date: _____

❑ Please resubmit claims

❑ Form not complete enough for verification by state - complete highlighted areas and resubmit

❑ TPL file already reflects the add/update. Our records were updated: _____

❑ Verification confirms Medicaid resource file correct as is - no update performed

❑ Change requested cannot be made. Reason:

_____

_____

_____

❑ Verification shows another current coverage that may be applicable:

_____

_____

_____

❑ Other: _____

_____

_____

_____

MO 886-2983 (2-97)

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
PRIOR AUTHORIZATION REQUEST

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The recipient must be Medicaid Eligible on the date of service or date the equipment or prosthesis is received by the recipient. **SEE REVERSE SIDE FOR INSTRUCTIONS.**

I. GENERAL INFORMATION

1.	2. NAME (LAST, FIRST, M.I.)	3. DATE OF BIRTH
4. ADDRESS (STREET, CITY, STATE, ZIP CODE)		5. MEDICAID NUMBER
6. PROGNOSIS	7. DIAGNOSIS CODE	8. DIAGNOSIS DESCRIPTION
9. NAME & ADDRESS OF FACILITY WHERE SERVICES ARE TO BE RENDERED IF OTHER THAN HOME OR OFFICE.		

II. HCY (EPSDT) SERVICE REQUEST (MAY REQUIRE PLAN OF CARE)

10. DATE OF HCY SCREEN	11. SCREENING ☐ FULL ☐ INTERPERIODIC ☐ PARTIAL	12. TYPE OF PARTIAL HCY SCREEN
13. SCREENING PROVIDER NAME	14. PROVIDER NUMBER	15. TELEPHONE NUMBER ( )

III. SERVICE INFORMATION (DO NOT WRITE IN SHADED AREAS) FOR STATE USE ONLY

16. REF. NO.	17. TYPE SERV.	18. PROCEDURE CODE	19. FROM	20. THROUGH	21. DESCRIPTION OF SERVICE/ITEM	22. QTY. OR UNITS	23. AMOUNT TO BE CHARGED	APPR.	DENIED	AMOUNT ALLOWED IF PRICED BY REPORT
(1)										
(2)										
(3)										
(4)										
(5)										
(6)										
(7)										
(8)										
(9)										
(10)										
(11)										
(12)										

24. DETAILED EXPLANATION OF MEDICAL NECESSITY FOR SERVICES/EQUIPMENT/PROCEDURE/PROSTHESIS (ATTACH ADDITIONAL PAGES IF NECESSARY)

IV. PROVIDER

25. PROVIDER NAME (AFFIX LABEL HERE)

26. ADDRESS

27. MEDICAID PROVIDER NUMBER

28. SIGNATURE | DATE

V. PRESCRIBING/PERFORMING PRACTITIONER

29. NAME | 30. TELEPHONE ( )

31. ADDRESS

32. DATE DISABILITY BEGAN | 33. PERIOD OF MEDICAL NEED IN MONTHS

I certify that the information given in Sections I and III of this form is true, accurate, and complete.

34. SIGNATURE OF PRESCRIBING PHYSICIAN/PRACTITIONER | DATE

VI. FOR STATE OFFICE USE ONLY

DENIAL REASON(S): REFER TO FIELD 16 ABOVE BY REFERENCE NUMBERS (REF. NO.)

IF APPROVED: services authorized to begin | DATE | REVIEWED BY SIGNATURE ▶

MO 886-0858 (8-01) MO 8809

INSTRUCTIONS FOR COMPLETION

I. GENERAL INFORMATION – To be completed by the provider requesting the prior authorization.

1. Leave Blank
2. Recipients Name – Enter the recipient's name as it appears on the Medicaid ID card. Enter the recipients current address.
3. Date of Birth – Enter the recipient's date of birth.
4. Address – Enter the recipients address, city, state, and zip.
5. Medicaid Number – Enter the recipient's 8-digit Medicaid identification number as shown on the Medicaid identification card or county letter of eligibility.
6. Prognosis – Enter the recipients prognosis.
7. Diagnosis Code – Enter the diagnosis code(s).
8. Diagnosis Description – Enter the diagnosis description. If there is more than one diagnosis, enter all descriptions appropriate to the services being requested.
9. Name and address of the facility where services are to be rendered if service is to be provided other than home or office.

II. HCY SERVICE REQUEST (Plan of care may be required, see your provider manual)

10. Date of HCY Screen – Enter the date the HCY Screen was done.
11. Screening -Check whether the screening performed was FULL, INTERPERIODIC, or PARTIAL.
12. Type of Partial HCY Screen – Enter the type of partial HCY Screen that was performed. (e.g., Vision, Hearing, etc.)
13. Screening Provider Name – Enter the provider's name who performed the screening.
14. Provider Number – Enter the provider's number who performed the screening.
15. Telephone Number – Enter the screening provider's telephone number including the area code.

III. SERVICE INFORMATION

16. Ref. No. = (Reference Number) A unique designator (1-12) identifying each separate line on the request.
17. Type of Service – Enter the appropriate type of service code for each procedure code.
18. Procedure Code – Enter the procedure code(s) for the services being requested.
19. From – Enter the from date that services will begin if authorization is approved (mm/dd/yy format).
20. Through – Enter the through date the services will terminate if authorization is approved (mm/dd/yy format).
21. Description of Service/Item – Enter a specific description of the service/item being requested.
22. Quantity or Units – Enter the quantity or units of service/item being requested.
23. Amount to be Charged – Enter the amount to be charged for the service.
24. Detailed Explanation of Medical Necessity of the service, equipment/procedure/prosthesis, etc. Attach additional page(s) as necessary. **Do not use another Prior Authorization Form.**

IV. PROVIDER REQUESTING PRIOR AUTHORIZATION

25. Provider Name – Attach a Medicaid provider label or enter the requested provider's information exactly as it appears on the label.
26. Address – If a Medicaid provider label is not used, enter the complete mailing address in this field.
27. Medicaid Provider Number – If a Medicaid provider label is not used, enter the provider's Medicaid Identification number.
28. Signature/Date -The provider of services should sign the request and indicate the date the form was completed. (Check your provider manual to determine if this field is required.)

V. PRESCRIBING/PERFORMING PRACTITIONER

This section must be completed for services which require a prescription such as Durable Medical Equipment, Physical Therapy, or for services which will be prescribed by a physician/practitioner that require Prior Authorization. Check your provider manual for additional instructions.

29. Name – Enter the name of the prescribing/performing/practitioner.
30. Telephone Number – Enter the prescribing/performing/practitioner telephone number including area code.
31. Address – Enter the address, city, state, and zip code.
32. Date Disability Began – Enter the date the disability began. For example, if a disability originated at birth, enter date of birth.
33. Period of Medical Need in Months – Enter the estimated number of months the recipient will need the equipment/services.
34. Signature of prescribing/performing/practitioner-The prescribing physician/practitioner must sign and indicate the date signed in mm/dd/yy format. **(Signature stamps are not acceptable)**

VI. FOR STATE OFFICE USE ONLY

Approval or denial for each line will be indicated in the box to the right of Section III. Also in this box the consultant will indicate allowed amount if procedure requires manual pricing.

At the bottom, the consultant may explain denials or make notations referencing the specific procedure code and description by number (1 thru 12). The consultant will sign or initial the form.

DS1926

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

MISSOURI MEDICAID ACCIDENT REPORT

Submit this form to notify the Medicaid agency of information you have regarding a Medicaid recipient's accident or injury. Please send the completed form to:

Department of Social Services
Divison of Medical Services
Attention: TPL Casualty/Tort Recovery
P.O. Box 6500
Jefferson City, Missouri 65102-6500

DO NOT send claims with this form. Your claims will not be processed for payment if attached to this form.

PROVIDER IDENTIFICATION NUMBER	DATE (MM/DD/YY)

PROVIDER NAME	DATES OF SERVICE

RECIPIENT NAME	MEDICAID NUMBER

DATE OF ACCIDENT/INJURY	APPROXIMATE TIME

TYPE OF ACCIDENT/INJURY

☐ AUTO ☐ WORK-RELATED ☐ OTHER (EXPLAIN)

ATTORNEY REPRESENTING RECIPIENT

RESPONSIBLE PARTY'S NAME	POLICY/CLAIM NUMBER

INSURANCE COMPANY NAME AND ADDRESS

HAVE YOU FILED A LIEN? IF YES, PLEASE PROVIDE DETAILS (I.E., AMOUNT, SERVICE DATES, ETC.)

☐ YES ☐ NO

REMARKS

Please attach copies of relevant documents (i.e. letters from attorneys, insurance companies, etc.) if applicable.

THANK YOU FOR YOUR ASSISTANCE.

MO 886-3018 (3-93) TPL-2P

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

APPLICATION FOR PROVIDER DIRECT DEPOSIT

PLEASE TYPE OR PRINT IN BLACK INK ******SEE INSTRUCTIONS ON REVERSE SIDE******

SECTION A **(All providers must complete this section)**

1.TYPE OF DIRECT DEPOSIT ACTION➡ □ New provider/Re-enrollment ✦□ Cancel Direct Deposit ✦□ Change Account/Route number

2.PROVIDER NAME: Complete provider name below as shown on provider labels. **If the Application for Provider Direct Deposit is for a clinic or group,** this form must be accompanied by an Authorization by Clinic Members which **must** contain a list of the provider name(s) and number(s) of all Advanced Practice Nurses, CRNA's, Physicians, and Diabetes Self-Management Training providers employed at that clinic/group, along with the **ORIGINAL** signature of the clinic owner or administrator. All other providers **MUST** complete a **separate** Application for Provider Direct Deposit containing their individual provider number and ***original*** signature. The clinic Application for Provider Direct Deposit will not be processed without the completed Authorization by Clinic Members. **A separate Application for Provider Direct Deposit must be completed for each provider number assigned.**

TYPE OR PRINT PROVIDER NAME HERE ➡

3.PROVIDER NUMBER (enter provider number as shown on provider label, **one provider number per application**)

_____ _____ _____ _____ _____ _____ _____ _____ _____

SECTION B **(Complete this section if you wish to enroll in direct deposit OR a change in account/route number(s) is requested.)**
(ATTACH a voided check showing the routing/account numbers, OR if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution completed below. The information completed on this form and the information on the attachment MUST match.

1. ROUTING NUMBER	2. DEPOSITOR ACCOUNT NUMBER
_ _ _ _ _ _ _ _ _	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

3. TYPE OF ACCOUNT (***must check one***) ➡ □ CHECKING ✦ □ SAVINGS

4. FINANCIAL INSTITUTION NAME	5. BRANCH NUMBER OR NAME (if applicable)
6. FINANCIAL INSTITUTION ADDRESS	7. TELEPHONE NUMBER (include area code)

SECTION C

I wish to participate in Direct Deposit and in doing so:

- ✦ I understand that in endorsing or depositing checks that payment will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State laws.
- ✦ I hereby authorize the State of Missouri to initiate credit entries (deposits) and to initiate, if necessary, debit entries (withdrawals) or adjustments for any **credit entries made in error** to my account designated above.
- ✦ I understand that the State of Missouri may terminate my enrollment in the Direct Deposit program if the State is legally obligated to withhold part or all payments for any reason.
- ✦ I understand that the Division of Medical Services may terminate my enrollment if I no longer meet the eligibility requirements.
- ✦ I understand that this document shall not constitute an amendment or assignment, of any nature whatsoever, of any contract, purchase order or obligation that I may have with an agency of the State of Missouri.

I am authorized to request Direct Deposit on behalf of this clinic/group and in doing so:

- ✦ I acknowledge that each individual in the clinic/group listed on the attached Authorization by Clinic Members has been informed of this request, and also informed that Medicaid funds will be sent to the depositor account specified above.
- ✦ I understand that each individual provider is responsible for all services provided and all billing done under the individual or clinic provider number, regardless to whom the reimbursement is paid. It is each individual provider's responsibility to use the proper billing code and indicate the length of time actually spent providing a service, regardless to whom the reimbursement is paid.

1. ❑ **I HEREBY CANCEL MY DIRECT DEPOSIT AUTHORIZATION** and authorize future payments to be sent to the current payment name and address recorded in the provider enrollment file. ***(Section A number 1 must also be completed)***

2. PROVIDER *ORIGINAL* SIGNATURE (*see requirements on reverse side of this form*)	TYPE OR PRINT NAME SIGNED & TITLE	3.DATE	4.TELEPHONE NUMBER

RETURN ORIGINAL FORM (and original Authorization by Clinic Members, if applicable) ***ALONG WITH A VOIDED CHECK OR LETTER FROM YOUR BANK (see Section B) TO:*** Division of Medical Services, Provider Enrollment Unit, PO Box 6500, Jefferson City MO 65102. Phone 573-751-2617

THIS FORM CANNOT BE FAXED

APPLICATION FOR PROVIDER DIRECT DEPOSIT INSTRUCTIONS

SECTION A ***ALL providers must complete this section***

1.**Type of Direct Deposit Action** -Check appropriate box. **If canceling direct deposit you must also complete Section C, #1.**
2. & 3. **Provider Name and Provider Number** - Enter provider name **and** number **EXACTLY** as shown on your provider label.

SECTION B ***This section must be complete for new applicants or re-enrollments and any changes to your direct deposit information.

ATTACH a voided check showing the routing/account numbers, **OR** if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution **to the back of this form.** The information completed on this form and the information on the attachment **MUST** match.

1. **Routing Number** - Enter your financial institution's routing number as printed on the bottom left portion of your business checks or deposit tickets (the first 9 digits). See Examples 1 and 2 below.
2. **Depositor Account Number** - Enter depositor account number as printed on the bottom of business checks following the routing number. It may be the first series of digits after the routing number followed by your check number (example 1) or it may be the series of digits which follow your check number (example 2). NOTE: The check number is not included in the depositor account number.

EXAMPLE 1

FINANCIAL INSTITUTION CHECK NO.4444
HOMETOWN, USA

PAY TO ORDER OF _____

121456789 8765432109812 4444

↕ Routing No. ↕ Depositor Acct No. ↕ Check No.

EXAMPLE 2

FINANCIAL INSTITUTION CHECK 4444
HOMETOWN, USA

PAY TO ORDER OF _____

121456789 4444 8765432109812

↕ Routing No. ↕ Check No. ↕ Depositor Acct No.

*********Credit Unions and Savings and Loan Associations may differ from the above examples. Please VERIFY your DEPOSITOR ACCOUNT NUMBER and ELECTRONIC ROUTING NUMBER with your financial institution.*********

SECTION C

1. **TO CANCEL OR REDESIGNATE:** Complete and submit a new Application for Provider Direct Deposit with the changed information and forward to the Division of Medical Services. **You must check the *CANCEL* box if you wish to *CANCEL* your direct deposit, Section A number 1 must also be completed.** If you elect to cancel direct deposit future payments will be sent to the current payment name and address recorded in the provider enrollment file. Provider direct deposits will continue to be deposited into the designated account at your financial institution until the Division of Medical Services is notified that you wish to ***cancel or redesignate*** your account and/or financial institution.
   DO NOT CLOSE AN OLD ACCOUNT UNTIL THE FIRST PAYMENT IS DEPOSITED INTO YOUR NEW ACCOUNT.
2. **PROVIDER SIGNATURE** - If the provider is enrolled as an individual, he/she must sign the form. Nursing homes, hospitals, independent laboratories and home health agencies must be signed by a person listed on form HCFA-1513 (disclosure of ownership) section III (a). If enrolled as a clinic or business (except those listed above) the form must be signed by the person with fiscal responsibility for the same. **Clinic applications must be accompanied by the Authorization by Clinic Members which must contain** a list of the name(s) and provider number(s) of all Advanced Practice Nurses, CRNA's, Physicians, and Diabetes Self-Management Training providers employed at that clinic location. **The Application for Provider Direct Deposit and the Authorization by Clinic Members MUST be signed by the same person. All other providers must complete** a separate Application for Provider Direct Deposit containing their individual provider number and **original** signature. **A SEPARATE FORM MUST BE COMPLETED FOR EACH PROVIDER NUMBER ASSIGNED.**

OTHER

1. **ATTACH** a voided check showing the routing/account numbers, **OR** if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution **to the back of this form.** The information completed on this form and the information on the attachment **MUST** match.
2. Direct deposit will be initiated after a properly completed application form is approved by the Division of Medical Services and the successful processing of a test transaction through the banking system.
3. **This form must be used to change** any financial institution information **or to cancel** your election to participate in direct deposit.
4. The Division of Medical Services will terminate or suspend the direct deposit option for administrative or legal actions including, but not limited to, ownership change, duly executed liens or levies, legal judgements, notice of bankruptcy, administrative sanctions for the purpose of ensuring program compliance, death of a provider and closure or abandonment of an account.
5. If any information completed on this form cannot be verified from the attachments or the form is completed incorrectly, the form(s) will be returned without being processed for direct deposit.

MISSOURI MEDICAID
SECOND SURGICAL OPINION FORM

PLEASE PRINT OR TYPE

SECTION I: TO BE COMPLETED BY PRIMARY (FIRST OPINION) PHYSICIAN

MO-8807

RECIPIENT'S NAME (FIRST) (M.I.) (LAST)				RECIPIENT'S MEDICAID I.D. NUMBER	
SURGICAL PROCEDURE DISCUSSED & RECOMMENDED			CPT-4 PROCEDURE CODES		ICD-9-CM DX. CODE
PERTINENT HISTORY SYMPTOMS AND PHYSICAL FINDINGS					
PHYSICIAN'S NAME (FIRST) (MI) (LAST)				Physician's Mo. Medicaid Provider No.	
PHYSICIAN'S OFFICE ADDRESS (Street) (City) (State) (Zip Code)				SPECIALITY, IF APPLICABLE	
APPOINTMENT DATE	PERSONAL SIGNATURE OF PRIMARY PHYSICIAN (NAME) (DATE)				

REFER THIS FORM TO THE SECOND OPINION PHYSICIAN WITH RESULTS OF PATIENT'S HISTORY AND PHYSICAL REPORT, LABORATORY DATA, X-RAYS, ETC. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND POSSIBLE CLAIM FILING NEEDS.

SECTION II: TO BE COMPLETED BY SECOND SURGICAL OPINION PHYSICIAN

NEED FOR SURGERY ☐ CONFIRMED ☐ NOT CONFIRMED	STATE REMARKS:				
SURGICAL PROCEDURE RECOMMENDED, IF SURGERY CONFIRMED			CPT-4 PROCEDURE CODES		ICD-9-CM DX. CODE
SECOND OPINION PHYSICIAN'S NAME (FIRST) (M.I.) (LAST)				Physician's Mo. Medicaid Provider No.	
SECOND OPINION PHYSICIAN'S OFFICE ADDRESS (Street) (City) (State) (Zip Code)				SPECIALITY, IF APPLICABLE	
APPOINTMENT DATE	PERSONAL SIGNATURE OF SECOND OPINION PHYSICIAN (NAME) (DATE)				

REFER THIS FORM BACK TO THE PRIMARY (FIRST OPINION) PHYSICIAN REFERENCED IN SECTION I. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND POSSIBLE CLAIM FILING NEEDS.

SECTION III: TO BE COMPLETED BY THIRD SURGICAL OPINION PHYSICIAN

(A third surgical opinion is covered by Mo. Medicaid only if the second surgical opinion physician did not recommend surgery)

NEED FOR SURGERY ☐ CONFIRMED ☐ NOT CONFIRMED	STATE REMARKS:				
SURGICAL PROCEDURE RECOMMENDED, IF SURGERY CONFIRMED			CPT-4 PROCEDURE CODES		ICD-9-CM DX. CODE
THIRD OPINION PHYSICIAN'S NAME (FIRST) (M.I.) (LAST)				Physician's Mo. Medicaid Provider No.	
THIRD OPINION PHYSICIAN'S OFFICE ADDRESS (Street) (City) (State) (Zip Code)				SPECIALITY, IF APPLICABLE	
APPOINTMENT DATE	PERSONAL SIGNATURE OF THIRD OPINION PHYSICIAN (NAME) (DATE)				

REFER THIS FORM BACK TO THE PRIMARY (FIRST OPINION) PHYSICIAN REFERENCED IN SECTION I. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND POSSIBLE CLAIM FILING NEEDS.

SECTION IV: TO BE COMPLETED BY SURGEON, IF SURGERY IS PERFORMED AT REQUEST OF RECIPIENT

SURGICAL PROCEDURE PERFORMED				CPT-4 PROCEDURE CODES	
ICD-9-CM DX. CODE	SPECIFY NAME AND ADDRESS OF SURGERY SITE				
DATE OF SURGERY					
SURGEON'S NAME (FIRST) (M.I.) (LAST)				Physician's Mo. Medicaid Provider No.	
SURGEON'S OFFICE ADDRESS (Street) (City) (State) (Zip Code)				SPECIALITY, IF APPLICABLE	
PERSONAL SIGNATURE OF SURGEON (NAME) (DATE)					

THE SURGEON MUST ATTACH THIS COMPLETED SECOND SURGICAL OPINION FORM TO HIS MEDICAID CLAIM FOR THE SURGICAL PROCEDURE. IT IS THE SURGEON'S RESPONSIBILITY TO FURNISH A COPY OF THIS COMPLETED FORM TO THE HOSPITAL/ AMBULATORY SURGICAL CARE CENTER, IN ORDER THAT THE FACILITY MAY BILL MEDICAID FOR RELATED CHARGES. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS.

DS1907 (02/01)

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

This form must be completed when a hysterectomy is to be performed which is not precluded from Medicaid reimbursement under Federal regulatory provisions at 42 CFR 441.255(a) and which is not exempted from the requirement for this documentation under provisions at 42 CFR 441.255(d) or (e).

The requirement for Acknowledgement of Receipt of Hysterectomy Information applies to an individual of any age. The form must be signed by the recipient or her representative, if any, prior to the surgery. Hysterectomies for family planning purposes are not payable through Medicaid or any other federally funded program, nor from the general relief or blind pension programs.

1. NAME OF RECIPIENT	2. MEDICAID ID NUMBER	3. NAME OF REPRESENTATIVE

4. SOURCE OF HYSTERECTOMY INFORMATION

PART I
TO BE COMPLETED BY THE PERSON WHO SECURES THE AUTHORIZATION TO PERFORM THE HYSTERECTOMY

5. I certify that I have informed the above named recipient and her representative, if any, **orally and in writing,** that the hysterectomy will render her permanently incapable of reproducing. I further certify that the purpose for performing the hysterectomy is:

6. SIGNATURE AND TITLE OF PERSON SECURING AUTHORIZATION	7. DATE (MONTH/DAY/YEAR)

8. PHYSICIAN / CLINIC NAME ▶	9. PROVIDER MEDICAID NUMBER

PART II COMPLETE A OR B

If B is completed, the reason the recipient is incapable of signing must be stated on the line provided in Item B. (B is not to be completed if the recipient is capable of signing in Item A.)

A. TO BE COMPLETED BY THE RECIPIENT RECEIVING THE HYSTERECTOMY PRIOR TO THE OPERATION

I have received, **orally and in writing,** information from the above named source, stating that the hysterectomy will render me permanently incapable of reproducing. I understand that I will not be able to become pregnant or bear children.

10. SIGNATURE OF RECIPIENT ▶	11. DATE (MONTH/DAY/YEAR)

B. TO BE COMPLETED BY A REPRESENTATIVE OF THE RECIPIENT RECEIVING THE HYSTERECTOMY

I, the representative named above, certify that the designated recipient accepts and understands that I am her representative and that she has received, **orally and in writing,** information from the above named source, stating that the hysterectomy will render her permanently incapable of reproducing. She understands that she will not be able to become pregnant or bear children.

12. REASON RECIPIENT INCAPABLE OF SIGNING

13. SIGNATURE OF REPRESENTATIVE ▶	14. RELATIONSHIP TO RECIPIENT	15. DATE (MONTH/DAY/YEAR)

MO 886-3280 (11/01/00)

Forms Request

Provider Number: _____ Date: _____
(Or Affix Provider Label Here)

Provider Name: _____

Provider Phone: _____

CLAIM FORMS	Quantity Preprinted	Blank
A. Pharmacy		
B. Dental		
C. HCFA 1500 (Rev 12/90)		
D. HCFA 1450 (UB-92) Inpatient / Outpatient/ Home Health		
F. Prior Authorization		

CROSSOVER STICKERS

G. Hospital Crossover Sticker (BLACK)	
H. SNF Crossover Sticker (RED)	
I. Part B Crossover Sticker (BLUE)	

If provider labels are needed with blank Claim Forms (A-F), check box. ☐

If you checked box, an equal number of labels will be supplied with Forms A-F. If you DID NOT check box, you WILL NOT receive labels.

If provider labels are needed and you are not ordering Forms A-F, indicate the quantity _____

SPECIAL MAILING INSTRUCTIONS:

Name: _____

Attn: _____

Street Address: _____

_____
(Not P.O. Box)

City: _____

State: _____ Zip: _____

ADDRESS CHANGE / CORRECTION:

Provider Number: _____

Name: _____

Street Address: _____

_____
(Not P.O. Box)

City: _____

State: _____ Zip: _____

Effective Date of Change: _____

ATTACHMENTS	Quantity
J. HCY Medical Screening Tool (All Pages)	
HCY Screening Forms by Age Group	
2. Newborn - 1 month/2 - 3 months	
3. 4 - 5 months/6 - 8 months	
4. 9 - 11 months/12 - 14 months	
5. 15 - 17 months/18 - 23 months	
6. 24 months/3 years	
7. 4 years/5 years	
8. 6 - 7 years/8 - 9 years	
9. 10 - 11 years/12 - 13 years	
*. 14 - 15 years/16 - 17 years	
&. 18 - 19 years/20 years	
K. HCY Lead Risk Assessment Guide	
L. Sterilization Consent	
M. Acknowledge Hysterectomy	
O. Hearing Aid Evaluation	
P. Medical Necessity	
Q. Adjustment Request	
R. Medical Necessity Long Term HPN	
S. Second Surgical Opinion	
T. Medical Necessity - Abortion	
U. Hospice Election Statement	
V. Oxygen - Respiratory Justification	
W. Notification of Termination of Hospice Benefits	
Y. Insurance Resource Report (TPL-4)	
Z. Accident Reporting Form (TPL-2P)	
1. Physician Certification of Terminal Illness	

_____
* Provider Signature: (Must Be Provider's Original Signature)

All requests are delivered to the address on your current provider label unless an address change or correction is requested above. An address change or correction changes your provider billing label. If Special Mailing Instructions are indicated, this and all future requests for forms from Verizon Data Services are delivered to this address until notice of a change is received. A change to Special Mailing Instructions does not change your provider billing label.

The above forms are provided to all participating Missouri Medicaid Providers. They are intended solely for Missouri Medicaid claims filing. Please complete the above information and return it to Verizon Data Services via any paper claims submission P.O. Box. For information regarding electronic claims submission, contact Verizon Data Services at (573) 635-3559.

DS1054 (Rev 11/00)

NONDISCRIMINATION POLICY STATEMENT

The Missouri Department of Social Services (DSS) is committed to the principles of equal employment opportunity and equal access to services. Accordingly, DSS shall take affirmative action to ensure that employees, applicants for employment, clients, potential clients, and contractors are treated equitably regardless of race, color, national origin, sex, age, disability, religion, or veteran status.

All DSS contracts and vendor agreements shall contain non-discrimination clauses as mandated by the Governor's Executive Order 94-3, Article XIII. Such clauses shall also contain assurances of compliance with Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended/ the Americans with Disabilities Act of 1990 (ADA), as amended; the Age Discrimination Act of 1975, as amended and other pertinent civil rights laws and regulations.

Applicants for, or recipients of services from DSS who believe they have been denied a service or benefit because of race, color, national origin, sex, age, disability or religion may file a complaint by calling the DSS Office for Civil Rights at 1-800-776-8014. Complaints may also be filed by contacting the local office or by writing to:

Missouri Department of Social Services
Office for Civil Rights
P. O. Box 1527
Jefferson City, MO 65102-1527

Or

U.S. Department of Health and Human Services
Office for Civil Rights
601 East 12th Street
Kansas City, MO 64106

Additionally, any person who believes they have been discriminated against in any United States Department of Agriculture related activity (e.g. food stamps, commodity food, etc.) may write to the United States Department of Agriculture at:

USDA Office of Civil Rights
1400 Independence Ave., SW
Mail Stop 9410
Washington, DC 20250

This policy shall be posted in a conspicuous place, accessible to all applicants for services, clients, employees, and applicants for employment, in all divisions, institutions and offices governed by DSS.

Director, Department of Social Services

04/02/03
Date